Medicare Financial Management Manual
Chapter 6 - Intermediary and Carrier Financial Reports

Table of Contents

(Rev. 188, 04-22-11)
(Rev. 191, 07-13-11)
(Rev. 195, 09-30-11)

Transmittals for Chapter 6

10 - Monthly Intermediary and Carrier Workload Report (Form CMS-1566 and CMS-1565) - General

(Rev. 6, 08-30-02)
A3-3892 and B3 13300

Intermediaries and carriers must prepare and submit to CMS each month the appropriate workload report (Form CMS-1566 for intermediaries and Form CMS-1565 for carriers) showing their workloads under the health insurance program. A separate report is required for each office assigned a separate contractor number. A separate report is required for each State assigned to the contractor, even if a separate contractor number is not assigned.

10.1 - Purpose and Scope

(Rev. 6, 08-30-02)
A3-3892.1 and B3 13300.1

The monthly Workload Report is the source of current information on the status of workloads. The data derived from the report, together with information from other sources, are used by CMS for such purposes as:

- Estimating workloads,
- Analyzing manpower and material requirements,
- Establishing operating norms and pars,
- Comparing the performance of individual intermediaries, and
- Identifying problem areas for resolution by the intermediary and/or CMS.

The workload report is designed to serve as a basic management tool for individual contractors. It provides data needed for budgeting, financing, work-planning, progress evaluation, and identification of operating problems.

The form must be submitted in accordance with the following instructions.

10.2 - Due Date

(Rev. 6, 08-30-02)
A3-3892.2

The report is transmitted to CMS CO via PC or terminal as soon as possible after the end of the month being reported, but no later than the 10th of the following month using instructions contained in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.

20 - Completing Page One of the Monthly Intermediary Workload Report

(Rev. 6, 08-30-02)
A3-3893

20.1 - Heading

(Rev. 6, 08-30-02)
A3-3893.1

This report is referenced as Form D in the CROWD system. The intermediary completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen. It first keys in the number of working days scheduled for the reporting period, less any days where no claims were processed as a result of a strike, snow storm, etc. It does not count Saturdays, Sundays, or holidays.

20.2 - Checking Reports

(Rev. 6, 08-30-02)
A3-3893.2

Before submitting Form D to CMS, the intermediary checks its completeness and arithmetical correctness. This check not only ensures accuracy but also uncovers other errors and inconsistencies. It uses the following checklist:

For each column:

- Line 1 + 2 = 3.
- Line 7 + 8 = 6.
- Line 10 + 11 = 9.
- Line 6 + 9 = 12.
- Line 3 + 4 - 12 = 13.
- Line 5 must be equal to or less than line 4.
- Line 14 must be equal to or less than line 13.
- Line 15 must be equal to or less than line 14.
- Line 18 + 19 + 20 + 21 = 17.
- Line 23 + 24 + 25 + 26 = 22.
- Line 28 + 29 + 30 + 31 = 27.

- Line 33 must be equal to or less than line 32.
- Line 35 + 36 + 37 = 34.
- Columns 2 + 3 + 4 + 5 + 6 = 1 for lines 1-33.
- Columns 2 + 3 = 1 for lines 34-37.

The intermediary bases all data reported on the CMS-1566 on actual counts and not on any types of estimates or samples.

20.3 - Type of Bill

(Rev. 6, 08-30-02)
A3-3893.3

The intermediary includes provider bills in the following columns of the report:

Column (1) Total - All provider bills.

Column (2) Inpatient Hospital - CMS-1450s submitted by hospitals for inpatient services with the following two-digit classification codes in Form Locator 4: 1-1 (inpatient hospital); and 4-1 (Religious Nonmedical Health Care Hospital- inpatient).

Column (3) Outpatient - CMS-1450s submitted by hospitals or SNFs for outpatient services with the following two-digit classification codes in Form Locator 4: 1-3 (Hospital-outpatient); 2-3 (SNF-outpatient); 4-3 (Religious Nonmedical Health Care Hospital-outpatient); 5-3 (Religious Nonmedical Health Care-SNF-outpatient); and 8-3 (Hospital-outpatient-surgical procedures-ASC).

Column (4) SNF - CMS-1450s with the following two-digit classification codes in Form Locator 4; 1-8 (hospital swing-bed); 2-1 (SNF-inpatient); 2-8 (SNF-swing bed); and 5-1 (Religious Nonmedical Health Care-SNF-inpatient).

Column (5) HHA - CMS-1450s submitted by HHAs, with the following two-digit classification codes in Form Locator 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); 3-4 (HHA-Other-Part B benefits). Include HH PPS Requests for Anticipated Payment (RAPs) with three-digit classification code 3-2-2 or 3-3-2 with dates of service 10/01/2000 and greater in addition to claims in this column.

Column (6) Other - CMS-1450s with the following two-digit classification codes in Form Locator 4:

1-2 (hospital inpatient-Part B benefits), 1-4 (hospital-Other-Part B benefits),

2-2 (SNF-inpatient-Part B benefits),

2-4 (SNF-Other-Part B benefits),

4-2 (Religious Nonmedical Health Care-inpatient-Part B benefits),

4-4 (Religious Nonmedical Health Care-inpatient-other),

5-2 (Religious Nonmedical Health Care-SNF inpatient-Part B benefits), 5-4 (Religious Nonmedical Health Care-SNF inpatient-other),

7-1, 7-2, 7-3, 7-4, 7-5 (Clinics-provider and independent RHCs, ESRD hospital-based or independent renal dialysis facilities, FQHCs, CMHCs, ORFs, and CORFS), and

8-1 and 8-2 (Hospices)

20.4 - Body of Report

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

SECTION A: INITIAL BILL PROCESSING OPERATION

The intermediary completes every type of bill column (1 through 6) for each reporting item as described below. It includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through a RO, another intermediary, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. It does not include:

- Bills received from institutional providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for them;

- Adjustment bills;

- Misdirected bills transferred to a carrier or another intermediary;

- HHA bills where no utilization is chargeable and no payment has been made, but which it has requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.); and

- Bills paid by an HMO and processed by the intermediary.

- Claims submitted by HHAs under the HH PPS with three-digit classification 3-2-9 or 3-3-9 are processed as adjustments to a previously submitted RAP record. However, the intermediary counts both HHPPS RAPs and claims as initial bills for this report. It does not exempt HH PPS claims as adjustments.

Opening Pending

Line 1 - Pending End of Last Month - The system will pre-fill the number pending from line 13 on the previous month's report.

Line 2 - Adjustments - If it is necessary to revise the pending figure for the close of the previous month because of inventories, reporting errors, etc., the intermediary enters the adjustment. It reports bills received near the end of the reporting month and placed under computer control sometime after the reporting month as bills received in the reporting month and **not** as bills received in the following month. In the event that some bills may not have been counted in the proper month's receipts, it counts them as adjustments to the opening pending in the subsequent month.

It enters on line 2 any necessary adjustments, preceded by a minus sign for negative adjustments, as appropriate.

Line 3 - Adjusted Opening Pending - The system will sum line 1 + line 2 to calculate the adjusted opening pending.

Receipts

Line 4 - Received During Month - The intermediary enters the total number of bills received for initial processing during the month.

It counts all bills immediately upon receipt regardless of whether or not they are put into the processing operation with the exception of those discussed below.

NOTE: It counts bills submitted by providers electronically after they have passed intermediary consistency edits. Prior to that time, it may return these bills or the entire tape reel (where magnetic tape is the medium of submission) without counting them as "received." However, once the bills or tapes have passed consistency edits and are counted as received, it uses the actual receipt date, not the date the edits are passed, in calculating pending and processing times.

If a bill belonging to one of the above-excluded categories is inadvertently counted as an initial bill received (e.g., certain adjustment bills unidentifiable at the time of receipt), the intermediary subtracts it from the receipt count when the bill is correctly identified.

Line 5 - Electronic Media Bills - The intermediary reports the net number of bills included on line 4 which were received in paperless form via electronic media from providers or their billing agencies and read directly into the intermediary claims processing system. It does not count on this line bills that it received in hardcopy and entered using an Optical Character Recognition (OCR) device. It does not count any bills received in hardcopy and transferred into electronic media by any entity working for it directly or under subcontract.

Clearances

Line 6 - Total CWF Bills (7 + 8) - The intermediary reports the number of initial bills (described in lines 7 and 8 below) processed through CWF and posted to CWF history. It does **not** include bills sent to CWF and rejected, unless they were resubmitted and posted to CWF history in the reporting month. It reports these bills in the month that it moves the bill to a processed location in the intermediary system after receipt of the host's response to pay or deny.

Line 7 - Payment Approved (CWF) - The intermediary enters the number of initial bills for which **it approved some payment** and for which the CWF host responded accepting the intermediary determination. It includes bills for which it approved payment in full or in part as a result of a determination that both the beneficiary and the provider were without fault (liability waiver). (See the Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections.) The intermediary reports here those fully adjudicated, approved-for-payment bills for which it has received a response from the host and are holding only due to the payment floor.

Line 8 - No Payment Approved (CWF) - The intermediary enters the number of initial bills processed through CWF during the month for which it approved no payment. It reports here those bills for which payment is not made because the deductible has not yet been met and payment is therefore applied to the deductible.

Line 9 - Total Non-CWF Bills (10 + 11) - The intermediary reports the number of initial bills (described in lines 10 and 11 below) processed outside CWF. Non-CWF bills are those either rejected by or not submitted to CWF that the intermediary finally adjudicates outside of CWF and therefore, are not posted to its history in the reporting month. The intermediary reports these bills as non-CWF, even if it plans to submit an informational record in the future. It reports such bills in the month in which it made the determination as to their final disposition.

It does **not** include home health bills where no utilization is chargeable and no payment has been made, but which it requested only to facilitate record keeping processes.

Line 10 - Payment Approved (Non-CWF) - The intermediary enters the number of initial bills processed outside CWF for which **it approved some payment**. It includes bills for which it approved payment in full or in part as a result of a determination that both the beneficiary and the provider were without fault (liability waiver). (See the Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections.)

Line 11 - No Payment Approved (Non-CWF) - The intermediary enters the number of initial bills processed outside CWF during the month for which it approved no payment.

Line 12 - Total Processed - The intermediary reports the sum of lines 6 and 9.

NOTE: It reports as processed on line 12 those bills it has moved to a processed location after being accepted by the host and is holding only due to the payment floor. However, for pages 2-12 of this report, it reports these bills as processed in the month during which the scheduled payment date falls (which may be in a subsequent reporting period).

The intermediary reports HMO bills it paid on line 12 and on pages 2-12. It does not report those bills paid by HMOs and processed by the intermediary on line 12 or on pages 2-12. It reports such HMO paid bills only on line 39 of page 1.

Closing Pending

Line 13 - Pending End of Month - The system will calculate the number of bills pending at the end of the month by adding line 3 (adjusted opening pending) to line 4 (receipts) and subtracting line 12 (total processed). The intermediary does not report as pending those bills that it has moved to a processed location after being accepted by the host and is holding only due to the payment floor. It reports such bills as processed on line 12.

Line 14 - Pending Longer Than 1 Month - The intermediary reports the number of bills included in line 13 pending longer than 1 month, i.e., those received prior to the reporting month but not processed to completion by the end of the reporting month. For example, for the reporting month of October 2001, it reports the number of bills pending at the end of October 2001 which had been received prior to October 1, 2001. It excludes bills received in the reporting month.

Line 15 - Pending Longer Than 2 Months - The intermediary reports the number of bills included in line 13 pending longer than 2 months, i.e., those received prior to the month preceding the reporting month but not processed to completion by the end of the reporting month. For example, for the reporting month of October 2001, it reports the number of bills pending at the end of October 2001 that had been received prior to September 1, 2001. It excludes bills received in the reporting month and one month prior to the reporting month.

Bill Investigations

Line 16 - Bill Investigations Initiated - The intermediary enters the number of initial bills that, for purposes of processing the claim to completion, required **outside** contact (via telephone, correspondence, or on-site visit) with providers, social security offices, or beneficiaries during the month. This includes contacting outside parties to resolve problems with covered level of care determinations, insufficient medical information or missing, inconsistent, or incorrect items on the bill. It does not count routine submissions by providers of additional medical evidence with bills as investigations in themselves. It counts only the number of bills requiring investigation, **not** the number of contacts made. It excludes bills reported as investigated in a prior month from this count even if the investigation continued into the reporting month. It does **not** count as bills investigated those returned to providers because they were incomplete, incorrect or inconsistent, and consequently were not counted as "receipts."

SECTION B: ADJUSTMENT BILLS

This section includes data on the number of adjustment bills processed and pending for the reporting month, including those generated by providers, PROs, or as a result of MSP or other activity. In reporting adjustment bills, the intermediary counts only the number of original bills requiring adjustment, not both the debit and credit

Claims submitted by HHAs under the HH PPS with three-digit classification 3-2-9 or 3-3-9 are processed as adjustments to a previously submitted RAP record. However, both HHPPS RAPs and claims are counted as initial bills. The intermediary does not report HH PPS claims as adjustments.

Clearances

Line 17 - Total CWF Processed (18+19+20+21) - The intermediary reports the number of adjustment bills processed through CWF during the month. It counts adjustment bills as processed in final only when acceptance from CWF is received. Since §3664 precludes the processing of a utilization adjustment bill until CWF accepts the bill upon which the adjustment action is based, no utilization adjustment billing action may be processed until CWF has accepted the original bill.

Line 18 - PRO Generated (CWF) - The intermediary reports the number of adjustment bills included in line 17 which were generated by PROs.

Line 19 - Provider Generated (CWF) - The intermediary reports the number of adjustment bills included in line 17 which were generated by providers.

Line 20 - MSP (CWF) - The intermediary reports the number of adjustment bills included in line 17 which were generated as a result of MSP activity.

Line 21 - Other (CWF) - The intermediary reports the number of adjustment bills included in line 17 which were generated by other than PROs, providers, or MSP activity. It includes HMO adjustments where the HMO acted as an intermediary and made payment on the initial bill.

Line 22 - Total Non-CWF Processed (23+24+25+26) - The intermediary reports the number of adjustment bills that it processed outside of CWF during the month. It counts such adjustment bills as processed in final only when no further action is required.

If it receives an adjustment bill from a provider when the original bill is still in its possession, it takes the final adjustment action on the original bill before it is submitted to CWF. It counts the adjustment bill as cleared when acceptance of the original bill is received from CWF.

Line 23 - PRO Generated (Non-CWF) - The intermediary reports the number of adjustment bills included in line 22 which were generated by PROs.

Line 24 - Provider Generated (Non-CWF) - The intermediary reports the number of adjustment bills included in line 22 which were generated by providers.

Line 25 - MSP (Non-CWF) - The intermediary reports the number of adjustment bills included in line 22 which were generated as a result of MSP activity.

Line 26 - Other (Non-CWF) - The intermediary reports the number of adjustment bills included in line 22 that were generated by other than PROs, providers, or MSP activity. It includes HMO adjustments where the HMO acted as an intermediary and made payment on the initial bill.

Pending

Line 27 - Total Pending (28+29+30+31) - The intermediary reports the number of adjustment bills which were not processed to completion by the end of the reporting month.

Line 28 - PRO Generated - The intermediary reports the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by PROs.

Line 29 - Provider Generated - The intermediary reports the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by providers.

Line 30 - MSP - The intermediary reports the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by MSP activity.

Line 31 - Other - The intermediary reports the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by it or by a source other than PROs, providers, or MSP activity. It includes HMO adjustments not processed to completion where the HMO acted as an intermediary and made payment on the initial bill.

SECTION C: MEDICAID CROSSOVER BILLS

This section presents data on the volume of Medicaid crossover bills sent to Medicaid State agencies or their fiscal agents.

Clearances

Line 32 - Transmitted to State Agencies - The intermediary enters the total number of Medicaid crossover bills transmitted to State agencies or their fiscal agents in the reporting month.

Line 33 - Transmitted Electronically - The intermediary enters the number of bills included in line 32 which were transmitted via electronic media to State agencies or their fiscal agents.

SECTION D: MISCELLANEOUS DATA

INQUIRIES

This section presents data on the volume of provider or beneficiary inquiries that were **processed** during the reporting month. Include only **processed** inquiries dealing with Medicare bill processing issues. These issues correspond to the workload budgeted under line 1 of the CMS-1523 budget form.

The intermediary counts inquiries as follows:

Beneficiary - It counts one per contact (telephone, walk-in, or written), regardless of the number of bills being questioned. For example, if a letter from a beneficiary requests information on the status of one or more bills, it counts the response (interim or final) as one written beneficiary inquiry. It counts each completed reply, terminated telephone conversation, or in-person discussion as processed, regardless of the need for subsequent contact on the same issue. Responses resulting from additional intermediary follow up or analysis, or from additional contact by the beneficiary, are separate inquiries. Beneficiary inquiries include those made by anyone on behalf of the beneficiary, **except** by a provider.

Provider - The intermediary counts one per contact (telephone, walk-in, or written). For example, if a provider calls or writes to obtain the status of 3, 6, or 10 separate bills, it count the response as 1 provider telephone or written inquiry.

It includes or excludes beneficiary and provider inquiries as follows:

- It counts as inquiries requests for Medicare information from beneficiaries or providers or their representatives that are directed to it for response.

- It does not count processed inquiries that are concerned solely with its line of business.

- It does not count inquiries concerned with professional relations activities.

- It does not count inquiries related solely to payment issues, MR or utilization review, MSP, audits, etc. These are areas for which it receives separate Medicare funding. This exclusion achieves comparability with the CMS-1523 budget form.

- It counts voice inquiries captured electronically as telephone inquiries, and electronic mail inquiries as written inquiries. It counts electronic inquiries only if the response is provided by telephone or in writing and requires its involvement. It does **not** count electronic inquiries if the provider can directly access its system to determine bill status.

- It counts Congressional inquiries according to whether they were made on behalf of a beneficiary or provider.

- It counts inquiries made by ROs or SSA district offices only if they concern a Medicare bill and are made on behalf of a beneficiary or provider.

- It counts misdirected **telephone** inquiries referred to another source for a final response. It does not count misdirected written inquiries.

- It does not count inquiries that are, in fact, explicit or implicit requests for reconsiderations or hearing. See Medicare Claims Processing Manual, Chapter 29, Appeals of Claims Decisions, for specifics on what is a request for reconsideration or review.

- It reports the number of inquiries from beneficiaries (column 2) and providers (column 3) processed during the reporting month, as follows:

Line 34 - Total - It reports in the appropriate column the total number of inquiries processed.

Line 35 - Telephone Inquiries - It reports in the appropriate column the total number of telephone inquiries processed.

Line 36 - Walk-in Inquiries - It reports in the appropriate column the total number of walk-in contacts processed.

Line 37 - Written Inquiries - It reports in the appropriate column the total number of written inquiries responded to.

OPTICAL CHARACTER RECOGNITION BILLS

Line 38 - Total Bills Received - It enters the total number of bills that it received in hardcopy and entered using an OCR device. It does not count these bills as electronic media bills on line 5, page 1, or in column 8, pages 2-11.

BILLS PAID BY HMOs

Line 39 - Total HMO Bills Processed - It enters the number of bills that were paid by HMOs and processed by it during the reporting month. It reports HMO bills paid by it on line 12 but **does not** report such bills on line 39.

MEDICARE SUMMARY NOTICES (MSNs)

Line 40 - Total MSNs Mailed - It enters the number of MSNs mailed to beneficiaries during the reporting month.

30 - Completing Pages 2 through 21 of Intermediary Workload Report

(Rev. 6, 08-30-02)
A3-3894

30.1 - Heading

(Rev. 6, 08-30-02)
A3-3894.1

These pages are referenced as Form U (pages 2-11) and Form E (pages 12-21) in the CROWD system. The intermediary completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

30.2 - Checking Reports

(Rev. 6, 08-30-02)
A3-3894.2

Before submitting Forms U and E to CMS, check for completeness and arithmetical accuracy, the intermediary uses the following checklist:

- For each column, line 38 must equal the sum of lines 1-37.
- For lines 1-38 on pages 2-11, column 1 must equal the sum of columns 2-7.
- For each of lines 1-38 on pages 2-11, column 8 must be less than or equal to column 1.
- For each of lines 1-38 on pages 12-21, column 1 must be less than or equal to column 2 for the corresponding bill type on pages 2-11.
- For each of lines 1-38 on pages 12-21, column 2 must be less than or equal to column 3 for the corresponding bill type on pages 2-11.

- The "Total" pages (pages 11 and 21) must equal the sum of all the bill types (pages 2-10 and 12-20, respectively) for each data element on the page, except line 39.

30.3 - Body of Report

(Rev. 6, 08-30-02)
A3-3894.3

SECTION E (1): CLAIMS PROCESSING TIMELINESS - ALL CLAIMS

Pages 2-11 of the CMS-1566 include data on intermediary activity in processing all bills to completion during the reporting period. The intermediary counts the bill as processed to completion on the "scheduled payment date," which is the date the check it issued is mailed, deposited by it in the provider's account, or transferred electronically. For PIP bills and no payment bills, the "scheduled payment date" is the date for payment bills in the same adjudication batch. Base data shown on reliable counts of all bill processing activity. **The intermediary does not estimate bill counts**. It reports data on initial bills only (including demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits). It does not include:

- Bills received from institutional providers if they are incomplete, incorrect, or inconsistent and consequently returned for clarification. Individual controls are not required for these bills;

- Adjustment bills;

- Misdirected bills transferred to a carrier or another intermediary;

- HHA bills where no utilization is chargeable and no payment has been made, but which the intermediary requested only to facilitate record keeping processes. (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills);

- Bills paid by an HMO and processed by the intermediary, and

- HH PPS RAPs with three-digit classification code 3-2-2 or 3-3-2 with dates of service 10/01/2001 and greater.

Apart from these exceptions, it includes in the report all bills (including PIP, EMC, provider and independent RHC, as well as HMO bills paid by it) processed to completion (i.e., paid bills, complete denials, and no payment bills) in the reporting month. It reports bills in the month the scheduled date of payment falls. See The Medicare Claims Processing Manual, Chapter 1, General Billing Requirements for the definition of scheduled payment date for all bills, including PIP and no payment bills. "Clean" bills are those that do not require investigation or development **external** to the intermediary operation on a prepayment basis. Bills that do not meet the definition of “clean” are "other" bills. See The Medicare Claims Processing Manual, Chapter 1, General Billing Requirements for examples of "clean" and "other." Bills paid are those for which some payment was made (i.e., payment greater than zero). Bills not paid are those for which no payment was made (i.e., bill charges applied completely toward deductible or fully denied).

On each page 2-11 (there is a separate page for each type of bill category listed below), the intermediary reports:

- In column 1, the total number of bills processed to completion;

- In column 2, the number of "non-PIP clean" bills paid;

- In column 3, the number of "non-PIP other" bills paid;

- In column 4, the number of "PIP clean" bills paid;

- In column 5, the number of "PIP other" bills paid;

- In column 6, the number of "clean" bills not paid;

- In column 7, the number of "other" bills not paid; and

- In column 8, the number of "clean" and "other" bills processed to completion, which were received via electronic media from providers or their billing agencies and read directly into the intermediary claims processing system. The intermediary does not count on this line bills that it received in hardcopy and entered using an OCR device. It does not count any bills received in hardcopy and transformed into electronic media by any entity working for it directly or under subcontract.

For each category, it shows the number processed to completion on the line corresponding to the number of days from receipt by it to the scheduled date of payment or other final action, if a no-pay bill. See The Medicare Claims Processing Manual, Chapter 1, General Billing Requirements for definition of receipt date.

NOTE: For bills received by tape, the date the intermediary receives the tape should be used as the receipt date and not the date the tape passes the edits.

To calculate the processing time for a claim, the intermediary subtracts the Julian receipt date from the processed to completion Julian date. When the processed to completion date falls in the year following the year of receipt, it adds to the Julian date of completion 365 (or 366 if the year of receipt is a leap year). If a claim is processed to completion on the same day it is received, the processing time is one day. This definition applies to all lines of the report, including line 39.

On line 39 the intermediary reports the mean processing time (PT) to one decimal place for each column. To calculate the mean PT, it adds the processing times for all the bills shown in lines 1-37 of that column and divides by line 38. It does not use the categories on the report to calculate the mean PT. Because of the aggregation of claims in lines 34-37, it must use the processing times for the individual claims as explained below to make this calculation.

Mean Processing Time Calculation for All Claims

- Subtract the Julian date of receipt from the Julian date of payment (or equivalent action for those not paid) for each claim.

- Sum the result for each claim into a total number of days for all claims.

- Divide this result by the total number of claims.

- Round to one decimal place.

EXAMPLE:

Claim	Julian Date Receipt	Paid	Counter by Days	Counter by Claims
A	91103	91133	30	1
B	91105	91206	101	2
C	91115	91177	62	3
D	91120	91213	93	4
E	91122	91215	93	5
F	91130	91223	93	6

Total Days = 30 + 101 + 62 + 93 + 93 + 93 = 472

Mean = 472/6 = 78.6666 = 78.7

The intermediary completes the report for each bill type:

- **Inpatient Hospital** - Of the bills reported on the "All Claims" page, it shows on page 2 data on the number of CMS-1450s submitted by hospitals for inpatient services with the following two-digit classification codes in Form Locator 4: 1-1 (inpatient hospital); and 4-1 (Religious Nonmedical Health Care Facility - Hospital-inpatient),

- **Outpatient** - Of the bills reported on the "All Claims" page, it shows on page 3 data on the number of CMS-1450s submitted by hospitals and SNFs for outpatient services with the following two-digit classification codes in Form Locator 4: 1-3 (hospital-outpatient); 2-3 (SNF-outpatient); 4-3 (Religious Nonmedical Health Care Facility - Hospital-outpatient); 5-3 (Religious Nonmedical Health Care Facility - SNF-outpatient); and 8-3 (hospital-outpatient surgical procedures - ASC),

- **SNF** - Of the bills reported on the "All Claims" page, it shows on page 4 data on the number of CMS-1450s with the following two-digit classification codes in Form Locator 4: 1-8 (hospital swing-bed); 2-1 (SNF-inpatient); 2-8 (SNF-swing-bed); and 5-1 (Religious Nonmedical Health Care Facility - SNF-inpatient),

- **HHA** - Of the bills reported on the "All Claims" page, it shows on page 5 data on the number of CMS-1450s with the following two-digit classification codes in Form Locator 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); and 3-4 (HHA-other-Part B benefits),

- **Hospice** - Of the bills reported on the "All Claims" page, it shows on page 6 data on the number of CMS-1450s with the following two-digit classification codes in Form Locator 4: 8-1 and 8-2 (Hospice),

- **CORF** - Of the bills reported on the "All Claims" page, it shows on page 7 data on the number of CMS-1450s with the following two-digit classification codes in Form Locator 4: 7-4 (Other Rehabilitation Facility) and 7-5 (Comprehensive Outpatient Rehabilitation Facility),

- **ESRD** - Of the bills reported on the "All Claims" page, it shows on page 8 data on the number of CMS-1450s with the following two-digit classification codes in Form Locator 4: 7-2 (hospital-based or independent renal dialysis facilities),

- **Lab** (All referred outpatient diagnostic services) - Of the bills reported on the "All Claims" page, it shows on page 9 data on the number of CMS-1450s with the following two-digit classification codes in Form Locator 4: 1-4 (Hospital-Other-Part B benefits); and 2-4 (SNF-Other-Part B benefits),

- **Other** - Of the bills reported on the "All Claims" page, it shows on page 10 data on the number of CMS-1450s not included in the previous eight bill categories, including provider and independent RHC bills, and

- **All Claims** - On page 11 it includes all bills processed to completion during the reporting month.

SECTION E(2): CLAIMS PROCESSING TIMELINESS - EMC CLAIMS AND ADJUSTMENTS FOR CPEP CPT CALCULATIONS

Pages 12-21 of the CMS-1566 the intermediary includes data on the non-PIP bills paid during the month they were received via electronic media. The basic instructions and definitions that apply to pages 2-11 (see above) also apply to pages 12-21. For each bill type, it reports the following information:

- Column 1 - The intermediary reports the number of EMC claims that were included in column 2 (paid non-PIP clean) for the corresponding bill type on pages 2-11.

- Column 2 - The intermediary reports the number of EMC claims that were included in column 3 (paid non-PIP other) for the corresponding bill type on pages 2-11.

For each bill type on pages 12-21, it reports the following adjustments for CPEP CPT calculations:

CWF - Claims that were beyond its control due to CWF. (See The Medicare Claims Processing Manual, Chapter 1, General Billing Requirements for definition of claims meeting this criteria.)

A. The number of EMC non-PIP clean claims paid beyond the EMC ceiling.
B. The number of paper non-PIP clean claims paid beyond the paper ceiling.
C. The number of all claims processed beyond 60 days.

WAIVER - Non-PIP claims paid under the claims payment floor for which the intermediary had a waiver from CMS.

D. The number of EMC non-PIP clean claims paid under the EMC floor.
E. The number of paper non-PIP clean claims paid under the paper floor.
F. The number of EMC non-PIP claims (clean and other) paid under the EMC floor plus the number of paper non-PIP claims (clean and other) paid under the paper floor.

30.4 - Completing Page 22 of Intermediary Workload Report

(Rev. 6, 08-30-02)
A3-3894.4

30.5 - Heading

(Rev. 6, 08-30-02)
A3-3894.5

This page is referenced as Form W in the CROWD system. The intermediary completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

30.6 - Checking Reports

(Rev. 6, 08-30-02)
A3-3894.6

Before transmitting page 22 to CMS, the intermediary checks its completeness and arithmetical accuracy. It uses the following checklist:

- For each column, line 1 must equal the sum of lines 2-10.
- For each column, line 11 must equal the sum of lines 12-20.
- For each line, column 1 must equal the sum of columns 2-6.

30.7 - Body of Report

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

SECTION F: INTEREST PAYMENT DATA

The intermediary reports on Page 22 of the CMS-1566 data on the bills on which it paid interest because it paid the bills after the required payment date per §9311 of the Omnibus Budget Reconciliation Act of 1986. Counts of bills processed reflect their status as of the last workday of the reporting calendar month. The intermediary bases data shown on reliable counts of all bill processing activity and not on estimates. It reports data on initial bills only. Note that HH PPS RAPs with three-digit classification code 3-2-2 or 3-3-2 with dates of service 10/01/2000 and greater are not subject to interest payment and should be excluded from this section. The intermediary includes all bills requiring interest payments in the month. It reports bills in the month the scheduled date of payment falls. See The Medicare Claims Processing, Chapter 1, General Billing Requirements, for a discussion of interest payments and the definition of scheduled payment date.

It the report for each column as follows:

- **Column 1 - Total** - It includes data for all bills for which interest payments were made in the reporting month.

- **Column 2 - Hospital** - Of the bills reported in column 1, it shows in column 2 data for CMS-1450s submitted by hospitals for **inpatient or outpatient** services with the following two-digit classification codes in Form Locator 4:

1-1	(inpatient hospital)
1-2	(inpatient hospital - Part B benefits)
1-3	(outpatient hospital)
1-4	(hospital - other Part B benefits)
4-1	(Religious Nonmedical Health Care Hospital - inpatient)
4-2	(Religious Nonmedical Health Care Hospital - inpatient Part B benefits)
4-3	(Religious Nonmedical Health Care Hospital - outpatient)
4-4	(Religious Nonmedical Health Care Hospital - inpatient other)
8-3	(Outpatient hospital surgical procedures - ASC)

- **Column 3 - SNF**--Of the bills reported in column 1, it shows in column 3 data for CMS- 1450s submitted with the following two-digit classification codes in Form Locator 4:

1-8	(hospital swing-bed)
2-1	(SNF - inpatient)
2-2	(SNF - inpatient Part B benefits)
2-3	(SNF - outpatient)
2-4	(SNF - other Part B benefits)
2-8	(SNF-swing-bed)
5-1	(Religious Nonmedical Health Care SNF - inpatient)
5-2	(Religious Nonmedical Health Care SNF - inpatient Part B benefits)
5-3	(Religious Nonmedical Health Care SNF - outpatient)
5-4	(Religious Nonmedical Health Care SNF - inpatient other)

- **Column 4 - HHA** - Of the bills reported in column 1, it shows in column 4 data for CMS-1450s with the following two digit classification codes in Form Locator 4: 3-2, 3-3, and 3-4.

- **Column 5 - Hospice** - Of the bills reported in column 1, it shows in column 5 data for CMS-1450s with the following two-digit classification codes in Form Locator 4: 8-1 and 8-2.

- **Column 6 - Remainder** - Of the bills reported in column 1 it shows in column 6 data for all CMS-1450s not included in columns 2-5 (including provider and independent RHCs).

On line 1, it shows the number of claims on which it paid interest in the reporting month. It reports on line 2 the number of claims included in line 1 for which it made payment one day after the required payment date (e.g., the required payment date is 25 days in FY 1999). Data for lines 3-10 are similar to those for line 2. It calculates the number of days late by subtracting the Julian date of receipt of the bill from the Julian scheduled payment date and then subtracting the required payment date (i.e., 25 in FY 1999). If the bill is paid in the year following the year of receipt, it adds 365 or 366 (if the year of receipt is a leap year) to the result, as appropriate.

On line 11, it shows the amount paid in interest on the bills reported in line 1. See The Medicare Claims Processing Manual, Chapter 1, General Billing Requirements on how to calculate interest payments. On lines 12-20 it shows the amounts paid in interest for bills reported in lines 2-10, respectively. It shows payment amounts on lines 11-20 to the nearest penny, including the decimal point.

Exhibit 1

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 1

Intermediary Name:	Reporting Period:
Intermediary Number:	Number of Working Days:

SECTION A: INITIAL BILL PROCESSING	TOTAL **(1)**	**INPATIENT** **(2)**	OUTPATIENT **(3)**	SNF **(4)**	HHA **(5)**	OTHER **(6)**
Opening Pending						
1. Opening Pending						
2. Adjustments (+ or -)						
3. Adj Opening Pending						
Receipts						
4. Received during Month						
5. Electronic Media						
Clearances						
6. Total CWF Bills						
7. Payment Approved						
8. No Payment Approved						
9. Total Non-CWF Bills						
10. Payment Approved						
11. No Payment Approved						
12. Total Processed						
Closing Pending						
13. Pending End of Month						
14. Longer than 1 Month						
15. Longer than 2 Months						

Exhibit 1 (Cont.)

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 1

Intermediary Name:	Reporting Period:
Intermediary Number:	Number of Working Days:

SECTION A: INITIAL BILL PROCESSING	TOTAL **(1)**	**INPATIENT** **(2)**	OUTPATIENT **(3)**	SNF **(4)**	HHA **(5)**	OTHER **(6)**
Bill Investigations						
16. Investigations Init						
SECTION B: ADJUSTMENT BILLS						
CWF Clearances						
17. Total CWF Processed						
18. PRO Generated						
19. Provider Generated						
20. MSP						
21. Other						
Non-CWF Clearances						
22. Total Non-CWF Prcsd						
23. PRO Generated						
24. Provider Generated						
25. MSP						
26. Other						

Exhibit 1 (Cont.)

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 1

Intermediary Name:			Reporting Period:			
Intermediary Number:			Number of Working Days:			
SECTION B: ADJUSTMENT BILLS	TOTAL **(1)**	**INPATIENT (2)**	OUT PATIENT **(3)**	SNF **(4)**	HHA **(5)**	OTHER **(6)**
Pending						
27. Total Pending						
28. PRO Generated						
29. Provider Generated						
30. MSP						
31. Other						
SECTION C: MEDICAID CROSSOVER BILLS						
Clearances						
32. Trans to St Agencies						
33. Trans Electronically						
SECTION D:						
MISCELLANEOUS DATA	TOTAL	BENEFICIARY	PROVIDER			
Inquiries						
34. Total Inquiries						
35. Telephone						
36. Walk-In						
37. Written						

Exhibit 1 (Cont.)

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 1

Intermediary Name:	Reporting Period:
Intermediary Number:	Number of Working Days:

SECTION D: MISCELLANEOUS DATA	TOTAL **(1)**	**INPATIENT** **(2)**	OUTPATIENT **(3)**	SNF **(4)**	HHA **(5)**	OTHER **(6)**
OCR Bills						
38. Total Received						
Bills Paid by HMOs						
39. Total Processed						
Medicare Summary Notices						
40. Total MSNs Mailed						

Exhibit 2

SECTION E(1): CLAIMS PROCESSING TIMELINESS - ALL CLAIMS

Form CMS 1566 - Medicare Program Intermediary Workload Report, Pages 2-11

Intermediary Number:		Bill Type:				Report Month:		
		******	********	**PAID**	********	***NOT PAID***		
		****Non-PIP****		*****PIP******				
DAYS TO PROCESS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
1.1								
2. 2								
3. 3								
4. 4								
5. 5								
6. 6								
7. 7								
8. 8								
9. 9								
10. 10								
11. 11								
12. 12								

Exhibit 2 (Cont.)

SECTION E(1): CLAIMS PROCESSING TIMELINESS--ALL CLAIMS

Form CMS 1566 - Medicare Program Intermediary Workload Report, Pages 2-11

Intermediary Number:			Bill Type:			Report Month:		
		*******	*******	***PAID***		NOT PAID		
		****Non-PIP****		******PIP******				
DAYS TO PROCESS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
13. 13								
14. 14								
15. 15								
16. 16								
17. 17								
18. 18								
19. 19								
20. 20								
21. 21								
22. 22								
23. 23								

Exhibit 2 (Cont.)

SECTION E(1): CLAIMS PROCESSING TIMELINESS--ALL CLAIMS

Form CMS 1566 - Medicare Program Intermediary Workload Report, Pages 2-11

Intermediary Number:			Bill Type:			Report Month:		
		********	*******	**PAID**		*NOT PAID*		
		****Non-PIP****		******PIP******				
DAYS TO PROCESS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
24. 24								
25. 25								
26. 26								
27. 27								
28. 28								
29. 29								
30. 30								
31. 31								
32. 32								
33. 33								

Exhibit 2 (Cont.)

SECTION E(1): CLAIMS PROCESSING TIMELINESS--ALL CLAIMS

Form CMS 1566 - Medicare Program Intermediary Workload Report, Pages 2-11

Intermediary Number:			Bill Type:			Report Month:		
		*******	******	**PAID**		**NOT PAID**		
		Non-PIP		****PIP****				
DAYS TO PROCESS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
34. 34-45								
35. 46-60								
36. 61-90								
37. 91+								
38. Total								
39. Mean PT								

CMS-1566, Page

Page number and bill type to be reported as follows:

Page 2 - Inpatient Hospital (INP)	Page 7 - CORF (COR)
Page 3 - Outpatient (OUT)	Page 8 - ESRD (ERD)
Page 4 - SNF (SNF)	Page 9 - Lab (LAB)
Page 5 - HHA (HHA)	Page 10 - Other (OTH)
Page 6 - Hospice (HPC)	Page 11 - Total (TOT)

EXHIBIT 3

SECTION F: INTEREST PAYMENT DATA

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 22

Intermediary Number:			Report Month:			
BILLS/PAYMENTS DAYS LATE	**TOTAL (1)**	**HOSPITAL (2)**	**SNF (3)**	**HHA (4)**	**HOSPICE (5)**	**REMAINDER (6)**
1. Total Bills						
2. 1						
3. 2						
4. 3						
5. 4						
6. 5						
7. 6-15						
8. 16-30						
9. 31-60						
10. 61+						
11. Total Paid						
12. 1						
13. 2						
14. 3						
15. 4						

Exhibit 3 (Cont.)

SECTION F: INTEREST PAYMENT DATA

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 22

Intermediary Number:			Report Month:			
BILLS/PAYMENTS DAYS LATE	**TOTAL (1)**	**HOSPITAL (2)**	**SNF (3)**	**HHA (4)**	**HOSPICE (5)**	**REMAINDER (6)**
16. 5						
17. 6-15						
18. 16-30						
19. 31-60						
20. 61+						

40 - Monthly PRO Adjustment Bill Report (Inactive)

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

The intermediary prepares and submits to CMS, by the 10th of each month following the reporting month, a PRO Adjustment Bill Report using the CROWD system. It submits a total page showing contractor activity for all PROs in the contractor's area. In addition, it submits a separate report for each PRO/State. For example, if the intermediary handles adjustment records for a PRO involving separate States, it should submit a separate report for each State. It reports all tape adjustment requests as well as hardcopy adjustment request records which the PRO has designated XXP (where XX is a two-digit numeric identifier) in accordance with the Medicare Claims Processing Manual, Chapter 4, Outpatient Billing. If the intermediary does not have activity for a certain PRO/State combination in a month, it shall not submit a report.

40.1 - Heading

(Rev. 6, 08-30-02)

A3-3895.1

The intermediary enters the contractor's assigned 5-digit ID and the PRO's 5-digit ID number in the indicated spaces. It shows the 2-digit State abbreviation. For the total page show "Total" in the PRO space. In the space labeled "Report Month/Year" enter the calendar month and year reported, e.g., show 0692 for June 1992.

40.2 - Body of Report

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

For all PRO adjustments, determine the appropriate column. Complete the report for each line as follows:

- **Line 1 - Opening Pending** - The intermediary enters the total number of adjustment request records reported as pending at the end of the previous month.

- **Line 2 - Revisions to Opening Pending** - The intermediary reports the net result of the number of request records that should not have been counted as adjustment request records pending at the end of the previous month (minus) and the number that were not counted but which should have been (plus).

- **Line 3 - Revised Opening Pending** - The intermediary enters line 1 plus line 2.

- **Line 4 - Electronic Adjustment Request Records Received** - The intermediary enters the number of electronic adjustment request records received from the PRO in the month.

- **Line 5 - Electronic Adjustment Request Records Rejected** - The intermediary enters the number of electronic adjustment request records reported on line 4 that failed contractor front end edits.

- **Line 6 - Electronic Adjustment Request Records Accepted** - The intermediary enters the difference of line 4 minus line 5.

- **Line 7 - Hard Copy Adjustment Requests Received** - The contractor shall enter the number of hard copy adjustment requests it received from its PRO(s). It shall count only hard copy requests the PRO has identified as 11P, 13P, 18P, 21P, or 83P.

- **Line 8 - Additional Bills to be Processed Due to Interim Bills**-The intermediary enters the number of interim bills to be adjusted as a result of PRO electronic or hard adjustment requests. It does not count interim bills for which no change is needed.

- **Line 9 - Total Adjustment Bills to be Processed** - The intermediary enters the total number of adjustment bills to be processed. This is the sum of lines 3, 6, 7, and 8.

- **Line 10 - Non-processable Adjustment Bills - Failed Batch/System Edits** - The intermediary enters the number of bills it could not process due to batch/system edits. It includes any requests which conflict with its history; e.g., utilization. It counts any interim bill which edits out of its system. These bills will be identified as non-processable on the Revisions to the Monthly PRO Adjustment Bill Report.

- **Line 11 - Total Adjustment Bills Processed** - The intermediary enters the total number of adjustment bills it has processed as a result of PRO adjustment requests (hard copy and electronic). It counts each bill when multiple bills are processed to satisfy one request.

- **Line 12 - Number Completed in 60 Days or Less** - The intermediary enters the number of adjustment bills processed in 60 days or less from the date it received the adjustment request record.

- **Line 13 - Number Completed in 61-90 Days** - The intermediary enters the number of adjustment bill processed in 61 to 90 days.

- **Line 14 - Number Completed in 91-120 Days** - The intermediary enters the number of adjustment bills processed in 91 to 120 days.

- **Line 15 - Number Completed Over 120 Days** - The intermediary enters the number of adjustment bills processed in 121 days or more.

- **Line 16 - Closing Pending** - The intermediary enters the total number of adjustment request records pending at the end of the report month.

40.3 - Checking Reports

(Rev. 6, 08-30-02)

A3-3895.3

Before transmitting the report, the intermediary checks for completeness and arithmetical accuracy. The line item edits apply to all columns. It uses the following checklist:

- Line 1 plus line 2 = line 3;
- Line 5 plus line 6 = line 4;
- Line 3 plus line 6 plus line 7 plus line 8 = line 9;
- Line 9 minus line 10 minus line 11 = line 16;
- Sum of lines 12 through 15 = line 11;
- Column b plus column c = column a;
- Sum of all PRO pages = Total pages;
- Total page line 11 = line 17, column (i) of CMS-1566; and
- Line 1 of current month's report must equal line 16 of previous month's report.

40.4 - Report Form

(Rev. 6, 08-30-02)
A3-3895.4

MONTHLY PRO ADJUSTMENT BILL REPORT			
INTERMEDIARY ID:	**PRO ID: STATE:**	**MONTH/YEAR:**	
	TOTAL (A)	**INPATIENT (B)**	**OUTPATIENT (C)**
1.Opening Pending			
2.Revisions to Opening Pending			
3.Revises Opening Pending			
4.Elec. Adj. Req. Rec. Received			
5.Elec. Adj. Rec. Rec. Rejected			
6.Elec. Adj. Rec. Received			
7.Hard-Copy Adj. Req. Rec. Accepted			
8.Addtl. Bills to be Proc. Due to Interim Bills			
9.Total Adj. Bills to be Proc.			

Report Form (Cont.)

MONTHLY PRO ADJUSTMENT BILL REPORT			
INTERMEDIARY ID:	**PRO ID: STATE:**	**MONTH/YEAR:**	
	TOTAL (A)	**INPATIENT (B)**	**OUTPATIENT (C)**
10.Nonprocessable Adjustment Bills-Failed Batch/System Edits			
11.Total Adj. Bills Processed			
12.No. Compl. in 60 Days or Less			
13.No. Compl. in 61-90 Days			
14.No. Compl. in 91-120 Days			
15.No. Compl. Over 120 Days			
16.Closing Pending			

50 - Quarterly Supplement To Intermediary Workload Report (Form CMS-1566A) - General

(Rev. 6, 08-30-02)
A3-3896

In addition to the monthly workload report, prepare and transmit to CMS a Quarterly Supplement to the Intermediary Workload Report showing the status and disposition of selected workloads. Complete a separate report for each office assigned a separate intermediary number.

50.1 - Purpose and Scope

(Rev. 6, 08-30-02)
A3-3896.1

The Quarterly Supplement to the Intermediary Workload Report - Pages 1 and 2, supplies CMS with current data on the number of bills processed for each State for which you service one or more providers. The Quarterly Supplement to the Intermediary Workload Report - Page 3, provides data on denials, HHA visits and waivers of liability.

50.2 - Due Date

(Rev. 6, 08-30-02)
A3-3896.2

Transmit the Quarterly Supplement to CMS CO via PC or terminal as soon as possible after the reporting quarter but no later than the 15th of the following month. Use instructions contained in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.

60 - Completing Quarterly Supplement To The Intermediary Workload Report, CMS-1566A, Pages 1 And 2

(Rev. 6, 08-30-02)
A3-3897

60.1 - Heading

(Rev. 6, 08-30-02)
A3-3897.1

These pages are referenced as Form C in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

60.2 - Checking Reports

(Rev. 6, 08-30-02)
A3-3897.2

Before submitting Form C to CMS, check its completeness and arithmetical accuracy. Use the following checklist:

- For each corresponding type of bill, line 1 (ALL) equals the sum of the number of bills processed reported on line 12 on the intermediary's monthly workload report (CROWD Form D) for the 3 months of the reporting period.

- For each column, line 1 (ALL) equals the sum of the lines reported for each State.

- For all lines of the report, column 1 (Total) equals the sum of the items in columns 2 + 3 + 4 + 5 + 6.

- The State code must be the two-letter postal abbreviation. Use code FO for all foreign claims not originating from a state, territory, or the District of Columbia.

60.3 - Type of Bill

(Rev. 6, 08-30-02)
A3-3897.3

The intermediary reports counts in total and by type of bill as shown below:

Column	**(1)**	**Total--All provider bills.**
Column	(2)	Inpatient Hospital--CMS-1450s submitted by hospitals for inpatient services, with the following two-digit classification codes in Form Locator 4: 1-1 (inpatient hospital); and 4-1 (Religious Nonmedical Health Care Hospital-inpatient).
Column	(3)	Outpatient--CMS-1450s submitted by hospitals or SNFs for outpatient services with the following two-digit classification codes in Form Locator 4: 1-3 (hospital-outpatient); 2-3 (SNF-outpatient); 4-3 Religious Nonmedical Health Care Hospital- outpatient); 5-3 (Religious Nonmedical Health Care SNF-outpatient); and 8- 3 (hospital- outpatient surgical procedures - ASC)
Column	(4)	SNF--CMS-1450s with the following two-digit classification codes in Form Locator 4: 1-8 (hospital-swing-bed); 2-1 (SNF-inpatient); 2-8 (SNF swing- bed); and 5-1 (Religious Nonmedical Health Care-SNF-inpatient).
Column	(5)	HHA--CMS-1450s submitted by HHAs with the following two digit classification codes in Form Locator 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); 3-4 (HHA-other-Part B-benefits)
Column	(6)	Other--CMS-1450s with the following two-digit classification codes in Form Locator 4: 1-2 (hospital inpatient-Part B benefits); 1-4 (hospital-other-Part B benefits); 2-2 (SNF-inpatient-Part B benefits); 2-4 (SNF-other-Part B benefits); 4-2 (Religious Nonmedical Health Care-inpatient-Part B benefits); 4-4 (Religious

Nonmedical Health Care-inpatient-other); 5-2 (Religious Nonmedical Health Care-SNF inpatient-Part B benefits); 5-4 (Religious Nonmedical Health Care-SNF inpatient-other); 7-1, 7-2, 7-3, 7-4, 7-5 (Clinics - provider and independent RHCs, FQHCs, ESRD hospital- based or independent renal dialysis facilities, FQHCs, CMHCs, ORFs and CORFs); and 8-1 and 8-2 (Hospices)

60.4 - Body of Report

(Rev. 6, 08-30-02)
A3-3897.4

Section A: Bills Processed by State of Provider - The intermediary reports in this section the claims workload for each State for which you service one or more providers. Break out by State the number of initial bills (including demand and no-pay bills) reported as processed on line 12 of Form D (see §20.4) over the 3 months of the reporting quarter.

NOTE: Categorize the information reported by the State of the individual **provider**, not the home office, if it is part of a chain organization.

Line 1 - All - For each column 1 through 6, the system will sum the number of claims reported on the individual State lines completed below. The numbers so calculated by the system must equal the sum of the numbers reported on line 12 of Form D for the 3 months of the reporting quarter.

State Lines - In the column just left of column (1), the intermediary enters the two-digit postal abbreviation of each State (or FO for foreign claims) which includes at least one provider for which you processed claims during the quarter.

It enters opposite each listed State the number of initial bills processed during the reporting quarter for providers located in the State. It reports the data in total in column 1, and by type of bill in columns 2 through 6.

70 - Completing Quarterly Supplement To The Intermediary Workload Report, CMS-1566A, Page 3

(Rev. 6, 08-30-02)
A3-3898

70.1 - Heading

(Rev. 6, 08-30-02)
A3-3898.1

This page is referenced as Form I in the CROWD system.

Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

70.2 - Checking Reports

(Rev. 6, 08-30-02)
A3-3898.2

Before submitting Form I to CMS, check for completeness and arithmetical accuracy. Use the following checklist:

- For all columns, line 1 + line 7 + line 8 must be equal to or less than line 1 of Form C.
- For all columns, line 1A + line 1B + line 1C must equal line 1.
- For all columns, line 1D must be equal to or less than line 1C.
- For all columns, line 2A must be equal to or less than line 1A.
- For all columns, line 2A must be equal to or less than line 2.
- For all columns, line 3A must be equal to or less than line 3.
- For all columns, line 7A must be equal to or less than line 7.
- For all columns, line 8B must be equal to or less than line 8.
- For all columns, lines 3 and 3A **must** be rounded to **whole** dollars. NOTE: This may cause you to force column 1 to equal the sum of columns 2-6.
- For lines 1 through 3A, lines 7 and 7A, and lines 8 and 8B, column 1 must equal the sum of columns 2-6.
- For columns 4 and 5, line 4 must be equal to or greater than line 1 of Form C.
- For columns 4 and 5, lines 5 through 6A must be equal to or greater than lines 1 through 2A, respectively (e.g., line 5 must be equal to or greater than line 1, line 5A must be equal to or greater than line 1A, etc.).
- For columns 4 and 5, line 5A + 5B + 5C must equal line 5.
- For columns 4 and 5, line 6A must be equal to or less than line 5A.
- For columns 4 and 5, line 6A must be equal to or less than line 6.
- For columns 4 and 5, line 7B must be equal to or greater than line 7A.

- For columns 4 and 5, line 8A must be equal to or greater than line 8.

- For columns 4 and 5, line 5 + line 7B + line 8A must be equal to or less than line 4.

70.3 - Type of Bill

(Rev. 6, 08-30-02)
A3-3898.3

The intermediary reports counts in total and by type of bill as outlined in §60.3 for Form C.

70.4 - Body of Report

(Rev. 6, 08-30-02)
A3-3898.4

Section B: Bill Denial Data

Line 1: Bills Denied-Total - The intermediary reports all full and partial denial determinations that it made during the reporting period. It reports only denial determinations resulting in its preparing and sending a notice to the beneficiary. It counts a denial when it denies (either in full or in part) bills submitted as covered. It includes counts where it made a denial determination but found both the beneficiary and the provider to be without fault under §213 of Public Law 92-603 and, therefore, made a determination to waive liability in full.

Also, it includes counts when it found only the provider to be at fault (i.e., it waived the beneficiary's liability). **It does not** count:

- Denials of no-pay or demand bills even though the contractor sends a denial notice.

- Denials of future services.

- Denials made by PROs.

Line 2: Bills Paid Under Waiver-Total - The intermediary reports the total number of bills on which you made a determination to waive the liability of both the beneficiary and the provider. Count determinations made at:

- Initial bill processing,

- Appeals process, and

- Any other time such as when you reopen your initial decision.

The intermediary does not count waiver determinations made by PROs.

Line 2A: Initial Bills Paid Under Waiver - The intermediary reports the number of bills on which you made a decision to waive the liability of both the beneficiary and the provider **during the initial adjudication of the bills.**

Line 3: Amount Reimbursed Under Waiver - The intermediary reports the amounts paid (to the nearest dollar) under the waiver provision for the bills reported on line 2. **Do not** include coinsurance amounts, charges applied toward the deductible, or reimbursement for services not under consideration with respect to the waiver provision. Where all services on a bill are paid in full (excluding the applicable deductible and coinsurance) as a combination of covered services and noncovered services paid under waiver and the exact dollar amount of the waiver payment is not available without contacting the provider, it reports an approximation of the waiver payment. In calculating this approximation, apply to total charges the proportion of waiver days to total days included on the bill, and subtract any applicable deductible or coinsurance for the waiver period.

Line 3A: Amount on Initial Bills - The intermediary reports the amounts paid (to the nearest dollar) under the waiver provision for the bills reported on line 2A.

Section C: Day/Visit Data

Line 4: Days/Visits Processed - The intermediary reports under column 4 the total number of days (both covered and noncovered) for SNF bills shown as processed in column 4, line 1 of Form C, for the same reporting period. It reports under column 5 the number of billed visits for HHA bills shown as processed in column 5, line 1 of Form C, for the same reporting period.

Line 5: Days/Visits Denied-Total - The intermediary reports under column 4 the number of SNF days denied on the bills reported on line 1. It reports under column 5 the number of HHA visits denied on the bills reported on line 1. Denied days/visits are those billed as covered which you determine to be noncovered.

Line 6: Days/Visits Paid Under Waiver of Liability - The intermediary reports under column 4 the number of SNF days on the bills reported on line 2 that were paid under the waiver provision. It reports under column 5 the number of HHA visits on the bills reported on line 2 that were paid under the waiver provision.

Line 6A: Days/Visits Paid Under Waiver on Initial Bills - The intermediary reports under column 4 the number of SNF days on the bills reported on line 2A that were paid under the waiver provision. It reports under column 5 the number of HHA visits on the bills reported on line 2A that were paid under the waiver provision.

Section D: Demand Bill Data

Line 7: Total Demand Bills - The intermediary reports under the appropriate column bills which the provider determined to be for noncovered services but which the beneficiary or his representative requested be filed in order to obtain a Medicare decision. It reports only bills identified by condition code 20. (See The Medicare Claims Processing Manual, Chapter 1, General Billing Requirements.) It reports the total number of bills processed during the reporting quarter, even if not manually reviewed.

Line 7A: Full/Partial Reversals - The intermediary reports the number of demand bills on which you fully or partially reversed the provider's decision that the services were noncovered.

Line 7B: Days/Visits on Reversals - The intermediary reports under column 4 the number of SNF days on the demand bills reported on line 7A. It reports under column 5 the number of HHA visits on the demand bills reported on line 7A (i.e., report days/visits for which you fully or partially reversed the provider's decision that they were noncovered).

Section E: No-Pay Bill Data

Line 8: Total No-Pay Bills - The intermediary reports under the appropriate column the total number of no-pay bills (**excluding the demand bills reported on line 7 Section D**) which are included in the total bills processed reported on line 1, page 1 of the Quarterly Supplement for the same reporting period. No-pay bills are those submitted by providers with no charges and/or covered days/visits. It does **not** report HHA bills where no utilization is chargeable and no payment has been made, but which you have requested only to facilitate recordkeeping processes.

Line 8A: Days/Visits on No-Pay Bills - The intermediary reports under column 4 the number of SNF days on the no-pay bills reported on line 8. It reports under column 5 the number of HHA visits on the no-pay bills reported on line 8.

Line 8B: MSP No-Pay Bills - The intermediary reports the number of no-pay bills included on line 8 where payment has been made in full by another insurer as primary payer.

70.5 - Completing Medicare Fraud Unit Quarterly Workload Status Report, CMS-1566B - General

(Rev. 6, 08-30-02)
A3-3898.5

The intermediary prepares and submits to CMS each quarter a report on the number of fraud workload items handled by your Medicare fraud unit. This information is required by CMS to budget for fraud and abuse activities, as well as to monitor the flow of work through the fraud units. Submit this form via the CROWD system no later than the 15th day following the close of the reporting quarter.

70.6 - Heading

(Rev. 6, 08-30-02)

A3-3898.6

This page is referenced as Form M in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

70.7 - Checking Reports

(Rev. 6, 08-30-02)
A3-3898.7

Before submitting Form M to CMS, check for completeness and arithmetical accuracy. Use the following checklist:

- For all columns, line 1 must equal line 8 of Form M for the previous quarter.
- For all columns, line 1 + line 2 = line 3.
- For all columns, line 6 + line 7 = line 5.
- For all columns, line 3 + line 4 - line 5 = line 8.
- For all lines, column 1 = column 2 + column 3 + column 4.

70.8 - Type of Fraud Workload Item

(Rev. 6, 08-30-02)
A3-3898.8

The intermediary reports fraud workload items in the following columns for all lines of Form M:

Column (1) - Total - All fraud workload items.

Column (2) - Beneficiary Complaints - The intermediary reports the number of complaints received from, or on behalf of, beneficiaries alleging fraud. Do not include complaints filed with the Office of the Inspector General (OIG) Hotline.

Column (3) - OIG Hotline - The intermediary reports the number of complaints received via the OIG Hotline.

Column (4) - Referrals and Other - The intermediary reports referrals and any other workload received by the fraud unit (e.g., provider complaints, internally generated referrals from medical review, special requests from OIG or CMS).

70.9 - Body of Report

(Rev. 6, 08-30-02)
A3-3898.9

Line 1 - Opening Pending - The system will pre-fill the number pending from line 8 of the previous quarter's report.

Line 2 - Adjustments - If it is necessary to revise the pending figure for the close of the previous quarter because of inventories, reporting errors, etc., enter the adjustment on this line. Precede negative adjustments with a minus sign.

Line 3 - Adjusted Pending - The system will sum line 1 + line 2 to calculate the adjusted opening pending.

Line 4 - Workload Received - The intermediary reports the number of complaints and referrals received in the fraud unit during the reporting period.

Line 5 - Total Cleared - The system will sum line 6 + line 7 to calculate the total number of complaints and referrals cleared by the fraud unit during the reporting period.

Line 6 - Cleared by Contractor - The intermediary reports the number of complaints and referrals cleared by the fraud unit by means other than referral to the OIG or designated agency. Include those that were:

- Closed as not substantive or not a fraud issue.
- Closed as not a fraud issue but referred to another contractor component for their review or action.
- Closed as not being a fraud issue but referred to an external component other than the OIG.

Line 7 - Cleared by Referral - The intermediary reports the number of complaints and referrals that were incorporated into cases referred formally to the OIG or designated agency for action (e.g., sanctions or prosecution).

Line 8 - Closing Pending - The system will calculate the closing pending for the quarter by adding line 3 to line 4 and subtracting line 5.

70.10 - Completing Quarterly Periodic Interim Payment (PIP) Report, CMS-1566C - General

(Rev. 6, 08-30-02)
A3-3898.10

The intermediary prepares and submits to CMS each quarter a report on the number of providers that you pay using the PIP method. This information is required so that CMS can monitor the number of providers being paid using the PIP method at each intermediary and nationally. Submit the form via the CROWD system no later than the 15th day following the close of the reporting quarter.

70.11 - Heading
(Rev. 6, 08-30-02)
A3-3898.11

This page is referenced as Form Q in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

70.12 - Checking Reports
(Rev. 6, 08-30-02)
A3-3898.12

Before submitting Form Q to CMS, check for completeness and arithmetical accuracy. Use the following checklist:

- For all columns, line 1 + line 2 - line 3 = line 4.

- For all lines, column 1 + column 2 + column 3 = column 4.

70.13 - PIP Items Reported - The intermediary reports the PIP workload items in the following lines for all columns of Form Q:
(Rev. 6, 08-30-02)
A3-3898.13

Line 1 - **PIP Providers - Beginning of Quarter** - The intermediary reports the number of PIP providers by type (hospital, SNF and HHA) and total at the beginning of the quarter.

Line 2 - **PIP Providers - Accretions** - The intermediary reports the number of providers by type (hospital, SNF and HHA) and total who elected during the reporting quarter to be paid under PIP.

Line 3 - **PIP Providers - Deletions** - The intermediary reports the number of providers by type (hospital, SNF and HHA) and total who elected during the reporting quarter to discontinue being reimbursed under the PIP method.

Line 4 - **PIP Providers - End of Quarter** - The intermediary reports the number of PIP providers by type (hospital, SNF and HHA) and total at the end of the quarter.

70.14 - Quarterly Supplement to the Intermediary Workload Report - CMS-1566A, Pages 1,2,3

(Rev. 6, 08-30-02)

A3-3898.14

QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
HFCA-1566A, PAGES 1 & 2 (CROWD FORM C)
INTERMEDIARY NUMBER_______   REPORT PERIOD_______

	SECTION A: BILLS PROCESSED BY STATE OF PROVIDER		**TOTAL 1**	**INP HOSP 2**	**OUTPATIENT 3**	**SNF 4**	**HHA 5**	**OTHER 6**
1 .		TOTAL - ALL						
		STATE CODE	XXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXX	XXXX	XXXXX	XXXXXX

Quarterly Supplement To Intermediary Workload Report (Cont.)

QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
HFCA-1566A, PAGE 3 (CROWD FORM I)

INTERMEDIARY NUMBER_______
REPORT PERIOD_______

	TOTAL 1	**INPATIENT 2**	**OUTPATIENT 3**	**SNF 4**	**HHA 5**	**OTHER 6**
SECTION B: BILL DENIAL DATA	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXX	XXXX	XXXXX
1. BILLS DENIED - TOTAL						
1A. MEDICAL - SUBJECT TO WAIVER	XXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXXXX	XXXXXX	XXXXXX
1B. MEDICAL - NOT SUBJECT TO WAIVER	XXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXXXX	XXXXXX	XXXXXX
1C. NONMEDICAL TOTAL	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXXXX	XXXXXX	XXXXXX
1D. NONMEDICAL MSP	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXXXX	XXXXXX	XXXXXX
2. BILLS PAID UNDER WAIVER TOTAL						
2A. INITIAL BILLS PAID UNDER WAIVER						

QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
HFCA-1566A, PAGE 3 (CROWD FORM I)

INTERMEDIARY NUMBER_______
REPORT PERIOD_______

	TOTAL 1	**INPATIENT 2**	**OUTPATIENT 3**	**SNF 4**	**HHA 5**	**OTHER 6**
3. AMOUNT REIMBURSED UNDER WAIVER						
3B. AMOUNT ON INITIAL BILLS						
SECTION C: DAY/VISIT DATA	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXX	XXXX	XXXXX
4. DAYS/VISITS PROCESSED	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX			XXXXX
5. DAYS/VISITS DENIED TOTAL NO-PAY BILLS	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX			XXXXX
5A. MEDICAL - SUBJECT TO WAIVER	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXXXX	XXXXXX	XXXXX
5B. MEDICAL - NOT SUBJECT TO WAIVER	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXXXX	XXXXXX	XXXXX
5C. NONMEDICALS	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXXX	XXXXXX	XXXXX

QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
HFCA-1566A, PAGE 3 (CROWD FORM I)

INTERMEDIARY NUMBER_______
REPORT PERIOD_______

	TOTAL 1	**INPATIENT 2**	**OUTPATIENT 3**	**SNF 4**	**HHA 5**	**OTHER 6**
6. DAYS/VISITS PAID UNDER WAIVER - TOTAL	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX			XXXXX
6A. DAYS/VISITS ON INITIAL BILLS	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX			XXXXX

Quarterly Supplement To Intermediary Workload Report (Cont.)

QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
HFCA-1566A, PAGE 3 (CROWD FORM I)

INTERMEDIARY NUMBER_______ REPORT PERIOD_______

	TOTAL 1	**INPATIENT 2**	**OUTPATIENT 3**	**SNF 4**	**HHA 5**	**OTHER 6**
SECTION D: DEMAND BILL DATA	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXX	XXXX	XXXXX
7. TOTAL DEMAND BILLS						
7A. FULL/PARTIAL REVERSALS						
7B. DAYS/VISITS ON REVERSALS	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX			XXXXX
SECTION E: NO-PAY BILLS	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXX	XXXX	XXXXX
8. TOTAL NO-PAY BILLS						
8A. DAYS/VISITS ON NO-PAY BILLS	XXXXXXX	XXXXXXXXXX	XXXXXXXXXXX			XXXXX
8B. MSP NO-PAY BILLS						

70.15 - Medicare Fraud Unit Quarterly workload Status Report - CMS-1566B

(Rev. 6, 08-30-02)

A3-3898.15

MEDICARE FRAUD UNIT QUARTERLY WORKLOAD STATUS REPORT
HFCA-1566B (CROWD FORM M)

INTERMEDIARY NUMBER_______ REPORT PERIOD_______

FRAUD WORKLOAD ITEM	TOTAL 1	BENEFICIARY COMPLAINT 2	OIG HOTLINE 3	REFERRAL & OTHERS 4
1. OPENING PENDING				
2. ADJUSTMENTS				
3. ADJUSTED PENDING				
4. WORKLOAD RECEIVED				
5. TOTAL CLEARED				
6. BY CONTRACTOR				
7. BY REFERRAL				
8. CLOSING PENDING				

70.16 - Quarterly Periodic Interim Payment (PIP) Report - Form CMS-1566C

(Rev. 6, 08-30-02)

A3-3898.16

QUARTERLY PERIODIC INTERIM PAYMENT (PIP) REPORT
FORM CMS-1566C (CROWD FORM Q)

INTERMEDIARY NUMBER_______ **REPORT PERIOD**

PIP PROVIDERS	HOSP. (1)	SNF (2)	HHA (3)	TOTAL (4)
1. BEGINNING OF QUARTER				
2. ACCRETIONS				
3. DELETIONS				
4. END OF QUARTER				

70.17 - Completing Quarterly Report on Provider Enrollment (Inactive)
(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Each quarter, the intermediary prepares and submits to CMS a report on the number of provider enrollment applications received, processed, and pending during the quarter. Include in your counts of provider enrollment applications, any change of ownership (CHOW) notices handled by you. It submits this report via the Contractor Reporting of Operational and Workload Data (CROWD) system no later than the fifteenth day following the close of the reporting quarter.

70.18 - Heading
(Rev. 6, 08-30-02)
A3-3898.18

This report is referenced as Form 3 in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

70.19 - Checking Reports
(Rev. 6, 08-30-02)
A3-3898.19

Before submitting Form 3 to CMS, check for completeness and arithmetical accuracy. Use the following checklist:

- For all lines, column 1 must equal the sum of columns 2-16.
- For all columns, line 1 must equal line 11 from the previous quarter.
- For all columns, line 3 must equal line 1 plus line 2.
- For all columns, line 6 must equal line 4 plus line 5.
- For all columns, line 10 must equal the sum of lines 7-9.
- For all columns, line 11 must equal line 3 plus line 6 minus line 10.
- For all columns, the sum of lines 12-17 must equal line 8.
- For all columns, the sum of lines 18-22 must equal line 9.
- For all columns, the sum of lines 23-26 must equal line 10.
- For all columns, the sum of lines 27-31 must equal line 11.
- For all columns, line 32 must equal line 37 from the previous quarter.

- For all columns, line 34 must equal line 32 plus line 33.
- For all columns, line 37 must equal line 34 plus line 35 minus line 36.
- For all columns, line 32 must be less than or equal to line 1.
- For all columns, line 34 must be less than or equal to line 3.
- For all columns, line 35 must be less than or equal to line 6.
- For all columns, line 36 must be less than or equal to line 10.
- For all columns, line 37 must be less than or equal to line 11.

70.20 - Type of Provider

(Rev. 6, 08-30-02)
A3-3898.20

The intermediary reports provider enrollment application data in the following columns for all lines on Form 3.

Column (1) - Total - The sum of columns 2-16 for each line.

Column (2) - Accredited Hospital - Provider applications indicating provider type as an accredited hospital.

Column (3) - Non-Accredited Hospital - Provider applications indicating provider type as a non-accredited hospital.

Column (4) - Religious Nonmedical Health Care Facility - Hospital - Provider applications indicating provider type as a Religious Nonmedical Health Care Facility - hospital.

Column (5) - Rural Primary Care Hospital - Provider applications indicating provider type as a rural primary care hospital.

Column (6) - SNF - Provider applications indicating provider type as a skilled nursing facility (i.e., long term care facility).

Column (7) - HHA. - Provider applications indicating provider type as a home health agency.

Column (8) - Hospice - Provider applications indicating provider type as a hospice facility.

Column (9) - ESRD - Provider applications indicating provider type as an end stage renal disease dialysis facility.

Column (10) - CORF - Provider applications indicating provider type as a comprehensive outpatient rehabilitation facility.

Column (11) - RHC - Provider applications indicating provider type as a rural health clinic.

Column (12) - FQHC - Provider applications indicating provider type as a federally qualified health center.

Column (13) - CMHC - Provider applications indicating provider type as a community mental health center.

Column (14) - IHS - Provider applications indicating provider type as an Indian Health Service facility.

Column (15) - Outp. Speech Path./Phy.Ther - Provider applications indicating provider type as either outpatient speech pathology or outpatient physical therapy facility.

Column (16) - Other - Provider applications indicating provider type other than those defined for columns 1 through 15.

70.21 - Completing Lines One through Eleven - Workload Operations

(Rev. 6, 08-30-02)
A3-3898.21

Line 1 - Pending End of Last Quarter - The CROWD system will automatically enter the value from line 11 on the previous quarter's report.

Line 2 - Adjustments to Pending - If it is necessary to revise the pending figure for the close of the previous quarter because of inventories taken or reporting errors discovered, enter the adjustment here. Adjustments can be positive or negative values. If entering a negative value, precede the number with a minus (-) sign.

Line 3 - Adjusted Opening Pending -The CROWD system will automatically sum the values on lines 1 and 2.

Line 4 - New Applications Received - The intermediary enters the number of applications received for the first time during the reporting quarter.

Line 5 - Returned Applications Resubmitted - The intermediary enters the number of applications received during the reporting quarter that had previously been received and returned to the applicant for correction/completion.

Line 6 - Total Applications Received -The CROWD system will automatically sum the values and lines 4 and 5.

Line 7 - Applications Recommended for Approval - The intermediary enters the number of applications that you recommended for approval (i.e., Medicare number issued) during the reporting quarter.

Line 8 - Applications Recommended for Denial - The intermediary enters the number of applications that you recommended for denial during the reporting quarter.

Line 9 - Applications Returned - The intermediary enters the number of applications returned to the applicant for corrections/completion during the reporting quarter.

Line 10 - Total Applications Processed -The CROWD system will automatically sum the values on lines 7, 8, and 9.

Line 11 - Pending End of Quarter -The CROWD system will automatically compute the number of applications pending at the end of the reporting quarter by adding the value on line 3 to the value on line 6 and then subtracting the value on line 10.

70.22 - Completing Lines Twelve through Seventeen - Reason for Denial Recommendation

(Rev. 6, 08-30-02)
A3-3898.22

Line 12 - Sanctioned From Medicare - The intermediary enters the number of applications that you recommended for denial because the applicant is currently excluded/sanctioned from Medicare.

Line 13 - Debarred/Excluded by Other Federal Agency - The intermediary enters the number of applications that you recommended for denial because the applicant had been disbarred, suspended, or excluded by any other Federal agency.

Line 14 - Not Professionally Licensed - The intermediary enters the number of applications that you recommended for denial because the applicant was not professionally licensed.

Line 15 - Business Address Invalid - The intermediary enters the number of applications that you recommended for denial because the applicant had an invalid business address.

Line 16 - Business Location Not Licensed - The intermediary enters the number of applications that you recommended for denial because the applicant=s business location was not properly licensed.

Line 17 - CMS Requirements Not Met - The intermediary enters the number of applications that you recommended for denial because the applicant did not meet all CMS requirements.

70.23 - Completing Lines Eighteen through Twenty-Two - Reason for Return

(Rev. 6, 08-30-02)
A3-3898.23

Line 18 - Incomplete - The intermediary enters the number of applications returned to the applicant because the application was incomplete.

Line 19 - Unverifiable Information - The intermediary enters the number of applications returned to the applicant because the application included unverifiable information.

Line 20 - Not Signed - The intermediary enters the number of applications returned to the applicant because the applicant did not sign the certification statement.

Line 21 - Invalid Billing Agreement - The intermediary enters the number of applications returned to the applicant because the billing agreement did not meet CMS requirements.

Line 22 - Other - The intermediary enters the number of applications returned to the applicant for any reason other than the ones indicated on lines 18 through 21.

70.24 - Completing Lines Twenty-Three through Twenty-Six - Application Processing Times

(Rev. 6, 08-30-02)
A3-3898.24

Line 23 - Number Under 21 Days - The intermediary enters the number of applications processed in less than 21 days from the date of receipt.

Line 24 - Number in 21-30 Days - The intermediary enters the number of applications processed in 21 through 30 days from the date of receipt.

Line 25 - Number in 31-40 Days - The intermediary enters the number of applications processed in 31 through 40 days from the date of receipt.

Line 26 - Number Over 40 Days - The intermediary enters the number of applications processed in more than 40 days from the date of receipt.

70.25 - Completing Lines Twenty-Seven through Thirty-One - Age of Applications Pending

(Rev. 6, 08-30-02)
A3-3898.25

Line 27 - Number Under 11 Days Old - The intermediary enters the number of applications included in line 11 which are 1-10 days old.

Line 28 - Number 11-20 Days Old - The intermediary enters the number of applications included in line 11 which are 11-20 days old.

Line 29 - Number 21-30 Days Old - The intermediary enters the number of applications included in line 11 which are 21-30 days old.

Line 30 - Number 31-40 Days Old - The intermediary enters the number of applications included in line 11 which are 31-40 days old.

Line 31 - Number Over 40 Days Old - The intermediary enters the number of applications included in line 11 which are over 40 days old.

70.26 - Completing Lines Thirty-Two through Thirty-Seven - CHOW Workloads

(Rev. 6, 08-30-02)
A3-3898.26

The intermediary reports in this section counts of your workloads dealing with CHOW notices included in lines 1, 2, 3, 6, 10, and 11.

Line 32 - Pending End of Last Quarter - The CROWD system will automatically enter the value from line 37 on the previous quarter's report. (This count represents the number of CHOWs included in line 1.)

Line 33 - Adjustments to Pending - If it is necessary to revise the pending figure for the close of the previous quarter because of inventories taken or reporting errors discovered, enter the adjustment here. Adjustments can be positive or negative values. If entering a negative value, precede the number with a minus (-) sign. (This count represents the number of CHOWs included in line 2.)

Line 34 - Adjusted Opening Pending -The CROWD system will automatically sum the values in lines 32 and 33. (This count represents the number of CHOWs included in line 3.)

Line 35 - CHOWs Received - The intermediary enters the number of applications shown in line 6 that represents CHOWs received during the reporting quarter.

Line 36 - CHOWs Processed - The intermediary enters the number of applications shown in line 10 that represents CHOWs processed during the reporting quarter.

Line 37 - Pending End of Quarter -The CROWD system will automatically compute the number of CHOWs pending at end of the reporting quarter by adding the value on line 34 to the value on line 35 and then subtracting the value on line 36. (This count represents the number of CHOWs included in line 11.)

70.27 - Exhibits

(Rev. 6, 08-30-02)
A3-3898.27

Exhibit 1 - Screen 1 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

Application Workloads	**Total (1)**	**Accrued Hospital (2)**	**Non-Accrued Hospital (3)**	**Religious Nonmedical Health Care Hospital (4)**	**Rural Prim Care Hospital (5)**
1. Pending End of Last Quarter					
2. Adjustments to Pending					
3. Adjusted Opening Pending					
4. New Applications Received					
5. Returned Appls Resubmitted					
6. Total Applications Received					
7. Applications Approval Recmd					
8. Applications Denial Recmd					
9. Applications Returned					
10. Total Applications Processed					
11. Pending End of Quarter					

SCREEN 1

Exhibit 2 - Screen 2 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

Application Workloads	**SNF (6)**	**HHA (7)**	**Hospice (8)**	**ESRD (9)**	**CORF (10)**
1. Pending End of Last Quarter					
2. Adjustments to Pending					
3. Adjusted Opening Pending					
4. New Applications Received					
5. Returned Appls Resubmitted					
6. Total Applications Received					
7. Applications Approval Recmd					
8. Applications Denial Recmd					
9. Applications Returned					
10. Total Applications Processed					
11. Pending End of Quarter					

SCREEN 2

Exhibit 3 - Screen 3 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

Application Workloads	**RHC (11)**	**FQHC (12)**	**CMHC (13)**	**IHS (14)**	**Outpatient Speech Pathology PhysicalTherapy (15)**	**Other (16)**
1. Pending End of Last Quarter						
2. Adjustments to Pending						
3. Adjusted Opening Pending						
4. New Applications Received						
5. Returned Appls Resubmitted						
6. Total Applications Received						
7. Applications Approval Recmd						
8. Applications Denial Recmd						
9. Applications Returned						
10. Total Applications Processed						
11. Pending End of Quarter						

SCREEN 3

Exhibit 4 - Screen 4 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

Application Workloads	**Total (1)**	**Accrued Hospital (2)**	**Non-Accrued Hospital (3)**	**Religious Nonmedical Health Care Hospital (4)**	**Rural Prime Care Hospital (5)**
Reason for Denial Recommendation					
12. Sanctioned from Medicare					
13. Debarred/Excluded by Other Fed					
14. Not Professionally Licensed					
15. Business Address Invalid					
16. Business Location Not Licensed					
17. CMS Requirements Not Met					
Reason for Return					
18. Incomplete					
19. Unverifiable Information					
20. Not Signed					
21. Invalid Billing Agreement					
22. Other					

SCREEN 4

Exhibit 5 - Screen 5 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

Application	SNF (6)	HHA (7)	Hospice (8)	ESRD (9)	CORF (10)
Reason for Denial Recommendation					
12. Sanctioned from Medicare					
13. Debarred/Excluded by Other Fed					
14. Not Professionally Licensed					
15. Business Address Invalid					
16. Business Location Not Licensed					
17. CMS Requirements Not Met					
Reason for Return					
18. Incomplete					
19. Unverifiable Information					
20. Not Signed					
21. Invalid Billing Agreement					
22. Other					

SCREEN 5

Exhibit 6 - Screen 6 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

Application Workloads	**RHC (11)**	**FQHC (12)**	**CMHC (13)**	**IHS (14)**	**Outpatient Speech Pathology/ Physical Therapy (15)**	**Other (16)**
Reasons for Denial Recommendation						
12. Sanctioned from Medicare						
13. Debarred/Excld by Other Fed						
14. Not Professionally Licensed						
15. Business Address Invalid						
16. Business Location Not Licens						
17. CMS Requirements Not Met						
Reason for Return						
18. Incomplete						
19. Unverifiable Information						
20. Not Signed						
21. Invalid Billing Agreement						
22. Other						

SCREEN 6

Exhibit 7 - Screen 7 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

Application Workloads	**Total (1)**	**Accrued Hospital (2)**	**Non-Accrued Hospital (3)**	**Religious Nonmedical Health Care Hospital (4)**	**Rural Prime Care Hospital (5)**
Application Processing Times					
23. Number Under 21 Days					
24. Number in 21-30 Days					
25. Number in 31-40 Days					
26. Number Over 40 Days					
Age of Applications Pending					
27. Number Under 11 Days Old					
28. Number 11-20 Days Old					
29. Number 21-30 Days Old					
30. Number 31-40 Days Old					
31. Number Over 40 Days Old					

SCREEN 7

Exhibit 8 - Screen 8 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

Application Workloads	**SNF (6)**	**HHA (7)**	**Hospice (8)**	**ESRD (9)**	**CORF (10)**
Application Processing Times					
23. Number Under 21 Days					
24. Number in 21-30 Days					
25. Number in 31-40 Days					
26. Number Over 40 Days					
Age of Applications Pending					
27. Number Under 11 Days Old					
28. Number 11-20 Days Old					
29. Number 21-30 Days Old					
30. Number 31-40 Days Old					
31. Number Over 40 Days Old					

SCREEN 8

Exhibit 9 - Screen 9 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

Application Workloads	RHC (11)	FQHC (12)	CMHC (13)	IHS (14)	Outpatient Speech Pathology/ Physical Therapy (15)	Other (16)
Application Processing Times						
23. Number Under 21 Days						
24. Number in 21-30 Days						
25. Number in 31-40 Days						
26. Number Over 40 Days						
Age of Applications Pending						
27. Number Under 11 Days Old						
28. Number 11-20 Days Old						
29. Number 21-30 Days Old						
30. Number 31-40 Days Old						
31. Number Over 40 Days Old						

SCREEN 9

Exhibit 10 - Screens 10 and 11 of Intermediary Provider Enrollment Quarterly Workload Report.

SCREEN 10

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

CHOW Workloads	**Total** **(1)**	**Accrued Hospital** **(2)**	**Non-Accrued Hospital** **(3)**	**Religious Nonmedical Health Care Hospital** **(4)**	**Rural Prime Care Hospital** **(5)**
32. Pending End of Last Quarter					
33. Adjustments to Pending					
34. Adjusted Opening Pending					
35. CHOWs Received					
36. CHOWs Processed					
37. Pending End of Quarter					

Exhibit 10 (Cont.)

Exhibit 10 - Screens 10 and 11 of Intermediary Provider Enrollment Quarterly Workload Report.

SCREEN 11

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

CHOW Workloads	**SNF (6)**	**HHA (7)**	**Hospice (8)**	**ESRD (9)**	**CORF (10)**
32. Pending End of Last Quarter					
33. Adjustments to Pending					
34. Adjusted Opening Pending					
35. CHOWs Received					
36. CHOWs Processed					
37. Pending End of Quarter					

Exhibit 11 - Screen 12 of Intermediary Provider Enrollment Quarterly Workload Report.

INTERMEDIARY NAME: **INTERMEDIARY NUMBER:**
REPORT PERIOD: **CROWD FORM 3**

CHOW Workloads	**RHC (11)**	**FQHC (12)**	**CMHC (13)**	**IHS (14)**	**Outpatient Speech Pathology/Physical Therapy (15)**	**Other (16)**
32. Pending End of Last Quarter						
33. Adjustments to Pending						
34. Adjusted Opening Pending						
35. CHOWs Received						
36. CHOWs Processed						
37. Pending End of Quarter						

SCREEN 12

80 - Monthly Intermediary Report On Medicare Secondary Payer Savings (Form CMS-1563)

(Rev. 6, 08-30-02)

A3-3899

80.1 - General

(Rev. 188, Issued: 04-22-11, Effective: 07-01-11, Implementation: 07-05-11)

NOTE: For MSP reporting effective April 2005, refer to the manual instructions located within Publication 100-05, Chapter 5, Section 60 (MSP Reports).

Each month the intermediary electronically transmits to CO a Monthly Intermediary Report on Medicare Secondary Payer Savings (CMS-1563) via the IBM PC. It continues to use existing dialup instructions and the RLINK software sent to it. (See §80.9). Hardcopy reports are not required. It transmits a separate report for each office assigned a separate intermediary number and also, for each State for which it have been designated the servicing intermediary for one or more providers. It is not required to complete an individual State report for those States in which it has had no MSP activity during the month (reports that would show zeros in every category, including pending).

80.2 - Purpose and Scope

(Rev. 6, 08-30-02)

A3-3899.2

The Monthly Intermediary Report on Medicare Secondary Payer Savings supplies CMS with current data on MSP savings and MSP pending workloads.

80.3 - Due Date

(Rev. 6, 08-30-02)

A3-3899.3

Form CMS-1563 is due in CO as soon as possible after the end of the month being reported, but not later than the 15th of the following month. Nonreceipt of the report by the 15th will result in a telephone contact with the intermediary to obtain required information.

80.4 - Form Heading

(Rev. 6, 08-30-02)

A3-3899.4

The intermediary enters its name, assigned number and the State in which the provider is located. In the space labeled "Reporting Period", it enters the numeric designation for month and year for which the report is being prepared, e.g., it shows 01/02 for January 2002.

80.5 - Savings Calculations

(Rev. 6, 08-30-02)

A3-3899.5

A. Reporting Dollar Values - The intermediary rounds all values to nearest whole dollar. This includes all amounts shown on lines 2, 4, 6, 8 and 80.

B. Checking Reports - Before mailing the reports, it checks their completeness and arithmetical accuracy as follows:

- Lines 1 + 3 + 5 = line 7 for all columns.
- Lines 2 + 4 + 6 = line 8 for all columns.
- Line 10 should be equal to, or greater than, line 9 for all columns, unless line 9 is equal to "0" in any column; in that case, line 10 should also be equal to "0" for the same column.
- For each line of the report column "i" (TOTAL), must equal the sum of the items in columns "ii" + "iii" + "iv" + "v" + "vi."

80.6 - Recording Savings

(Rev. 6, 08-30-02)
A3-3899.6

The intermediary controls all claims from which it extracts MSP savings and is able to verify all amounts recorded on the CMS-1563.

A. MSP Savings File - It retains claims specific key identifying information on each claim counted as savings on the CMS-1563. At a minimum, it records the beneficiary's name, HICN, type/dates of service, claim control number, billed charges and savings amounts reported.

B. Savings Data From Non-Medicare Sources - If it records savings from data it obtained from its "private side" records or any other "outside" source, it must be able to extract the same claims specific information noted above, i.e., it must verify that Medicare covered services are involved and be able to calculate "what Medicare would have paid." In addition, it must compare this data with the data contained in its MSP savings file to ensure that savings have not previously been recorded for the same claims. If savings have not previously been taken for the claim, it counts them as savings on the CMS-1563 and enters them into its MSP savings file.

80.7 - Source of Savings - The intermediary reports data by total and by source as shown below:

(Rev. 6, 08-30-02)
A3-3899.7

Column (i)	**Total**--All MSP savings regardless of source.
Column (ii)	**Workers' Compensation, Black Lung, and VA -** It includes data related to all MSP savings resulting from medical benefits provided by the WC Plans of the 50 States, the District of Columbia, Guam and Puerto Rico. It also includes Federal WC provided under the Federal Employee's Compensation Act, the U. S. Longshoremens' and Harborworkers' Compensation Act and its extensions, the Federal Coal

Mine Health and Safety Act of 1969 as amended (the Federal BL Program), and any fee-for-service medical care paid for by the VA. It keeps separate records for each distinct category (WC, BL or VA) as this may become a reporting requirement in the future.

Column (iii) **Working Aged -** It includes data related to all MSP savings resulting from benefits payable under an EGHP for beneficiaries aged 65 and older who are covered by reason of their own employment or the employment of a spouse of any age. Section 3491 further defines the working aged provisions.

Column (iv) **ESRD** - It includes data related to all MSP savings resulting from benefits payable under an EGHP for individuals who are entitled to Medicare benefits solely on the basis of ESRD during a period of up to 12 months. The period during which Medicare pays secondary benefits is defined in the Medicare Claims Processing Manual, Chapter 29, Coordination with Medigap insurers.

Column (v) **Auto Medical, No Fault and Liability Insurance -** It includes data related to all MSP savings resulting from:

- **Automobile Medical or No Fault Insurance** - Insurance coverage (including a self-insured plan) that pays for all, or part, of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile, regardless of who may have been responsible for the accident. (This insurance is sometimes called "personal injury protection," "medical payments coverage" or "medical expense coverage.")

- **Liability Insurance -** Insurance (including a self-insured plan) that provides payment based on legal liability for injury, illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. It does not include situations where a beneficiary receives medical payment under his or her own homeowners' insurance.

Column (vi) **Disabled -** It includes data related to all MSP savings resulting from situations where Medicare is the secondary payer for disabled beneficiaries under age 65 (except ESRD beneficiaries) who elect to be covered by a large group health plan (LGHP) as a current employee or family member of such employee. A LGHP is any health plan that covers employees of at least one employer who normally employs 100 or more employees. The disabled provisions apply to items and services furnished on or after January l, 1987 and before January l, 1992

80.8 - Type of Savings - The intermediary reports data by type of savings as shown below
(Rev. 6, 08-30-02)
A3-3899.8

Unpaid (Cost Avoided) MSP Claims

Unpaid (cost avoided) claims are those that the intermediary has returned without payment because it has strong evidence that another insurer is the primary payer and there is no indication that payment has been requested from that payer. The information indicating MSP involvement may be contained in the intermediary's files, on the query reply, or on the claim itself. In addition, any information it obtains from a non-Medicare source and uses as the basis for claiming cost avoidance savings must meet the criteria in §80.6B.

Information considered adequate for claiming cost avoidance savings includes statements on the claim noting "automobile accident," "collision", or the name of the automobile insurer. Another example would be previous information obtained showing EGHP coverage exits. The intermediary does not count claims it develops as "possible" MSP situations based on routine edits as cost avoidance savings unless it has previous information that another payer has primary responsibility. For example, "trauma code" edits are not, by themselves, considered strong evidence that Medicare is the secondary payer.

Line 1 - Number - The intermediary reports the total number of cost avoided claims from which it is recording savings on the report.

Line 2 - Dollar Value - The intermediary reports the total dollar value of the potential Medicare payments calculated for the claims on Line 1 that will be saved if the primary payer makes a payment which relieves Medicare of all payment liability.

It shows as the amount cost avoided what Medicare would have paid. **It does not count total charges as cost avoided savings.** The cost avoided amount is the "Medicare payment rate" or the "current Medicare interim reimbursement amount" less any co-insurance amount applicable. It reduces Part B services subject to coinsurance for the coinsurance amount or it may use a "coinsurance reduction factor" of 19 percent to calculate coinsurance charges for <u>all</u> Part B services. It does not have to query for deductible status, but may assume that the deductible has been met.

Tracking/Adjusting Cost Avoidance Savings

Cost avoidance savings may not duplicate savings reported as full or partial recoveries and may not be shown where Medicare ultimately makes primary payment. To prevent duplicate counting, the intermediary suspends all claims it returns unpaid. It sets up a control on each claim returned for development. It maintains this control for 75 days, unless it receives further information before that time which allows it to process the claim. If no further information on the claim is received, it may deny the claim after 75 days. It is not required to continue tracking the claim, but retains the key identifying information on the claim, as described in §80.6A.

CMS prefers the intermediary to show cost avoidance savings only **after** 75 days have elapsed. However, it has the option of counting the savings when the claim is initially suspended or at any time during the suspension period. If it chooses the latter alternative, it must adjust its cost avoidance savings if the claim is resubmitted during the suspension period with information showing it is not a legitimate cost avoidance.

The following situations require special consideration if cost avoidance savings are counted before the 75 day suspense period has ended:

- A claim returned (and counted as cost avoided) is paid **in part** by another payer and the provider resubmits it for secondary payment.

- A claim returned (and counted as cost avoided) is denied by the other payer and the provider resubmits it for primary payment.

- A claim returned (and counted as cost avoided) is paid **in full** by the other payer and the provider submits a no-payment bill. The intermediary shows "full recovery" savings and not cost avoidance.

In these situations, it adjusts its cost avoidance savings figures by deducting or "backing out" the applicable amounts. It makes the adjustments in the reporting month in which a final determination is rendered. The following chart outlines the correct reporting of savings in each situation.

ADJUSTMENTS TO REPORTED MSP COST AVOIDANCE SAVINGS

CLAIMS PROCESSING ACTIONS	MSP SAVINGS REPORTED		
	Cost Avoidance	Partial Recoveries	Full Recoveries
I. Partial Recovery Adjustment			
o MSP situation indicated. Medicare payment calculated to be $1200 if Medicare was primary payer. Claim is returned to provider.	$ 1,200		
o Provider resubmits the claim showing $900 paid by the other insurer. Medicare secondary payment of $300 is made.	$ (1,200) *	$ 900	
II. "Other Payer Denial" Adjustment			
• MSP situation indicated - Medicare "primary" payment, $2,000. Claim is returned to provider.	$ 2,000		
• Other payer denies claim. Medicare found to be primary and Medicare payment of $2,000 is made.	$ (2,000) *		
III. Full Recovery Adjustment			
• MSP situation indicated - Medicare "primary" payment, $900. Claim is returned to provider.	$ 900		
• Provider submits a "no-payment" bill showing full payment by the other payer.	$ (900) *		$ 900

*Amounts "backed out" of cost avoidance savings figures.

Full Recoveries

Line 3 - Number - The intermediary reports the number of full recoveries made during the month.

Line 4 - Dollar Value - The intermediary reports the dollar value of full recoveries made during the month.

Full Recoveries are claims where the primary payer made a payment that relieved Medicare of all payment liability. Full recoveries can be either prepayment or postpayment. The intermediary counts full recoveries in the month in which it recovers the full payment or receives a no-payment bill for **prepayment** full recovery cases. Where the "full recovery" is paid in installments, it counts the claim as pending until all monies have been received. Instructions for processing full recovery claims are in the Medicare Claims Processing Manual, Chapter 29, Coordination with Medigap insurers.

A. Prepayment Full Recovery - A prepayment full recovery occurs when a primary payer makes full payment on a charge before Medicare makes any payment.

EXAMPLE: A hospital identifies an EGHP as the primary payer, submits its charge to that insurer, and the EGHP pays the hospital's full cost. The intermediary subsequently receive a "no pay" bill in accordance with the Medicare Claims Processing Manual, Chapter 29, Coordination with Medigap insurers. It determines what it would have paid if the EGHP had not made payment and records that total as a full recovery savings.

B. Postpayment Full Recovery - A postpayment full recovery occurs when a primary payer makes full payment on a charge after Medicare has paid.

EXAMPLE: Medicare paid a hospital bill for charges incurred as a result of an automobile accident. Subsequently, an auto liability insurer reimburses the Medicare beneficiary for the full amount of the medical expenses and the beneficiary refunds that amount to the program. The intermediary counts the amount of Medicare's initial payment as a postpayment full recovery.

The intermediary records as savings, that portion of a full recovery paid to an attorney or other agent as Medicare's share of the recovery cost. Consequently, there may be instances where it has made a full recovery but does not get back the full amount paid. When it refers a case to the RO for recovery action, however, **it does not** record any savings at that point. Savings from a compromise or "subrogation" case may be recorded only **after** a final determination. The intermediary does not count these cases for CPEP credit prior to final settlement.

EXAMPLE: A beneficiary incurs a $1,000 physician's bill and a $5,000 hospital bill as a result of injuries sustained in an automobile accident. Assuming that all deductibles are satisfied, Part B pays $800 toward the physician's charges, and Part A covers the hospital bill in full. After litigation, a liability insurer agrees to pay $6,000 for the beneficiary's medical expenses from which the attorney takes a fee. (If the attorney's fee were 33 percent, the dollar recovery would be $4,000.) The Part B contractor can record $800 in Full Recovery savings. The intermediary is also allowed to count its payment as a Full Recovery savings even though the amount recovered, due to attorney's fees, does not equal what was paid.

Partial Recoveries

Line 5 - Number - The intermediary reports the number of partial recoveries made during the month.

Line 6 - Dollar Value - The intermediary reports the dollar value of partial recoveries made during the month.

Partial recoveries are those savings realized when a primary payer makes a payment which covers only a part of the Medicare allowable charge, leaving Medicare with a balance to pay. The intermediary uses the following formula in computing the savings from a partial recovery:

- The dollar amount of Medicare benefits available for the services or supplies (calculated as if Medicare were the primary payer) less the Medicare benefits paid for the services or supplies, equals the partial recovery savings. (Primary Payment -Actual Payment = Partial Recovery Savings)

The intermediary counts partial recoveries in the month when it takes final action on the claim (either making a payment supplemental to that of the primary payer or making a partial recovery from a payment by the primary payer). Instructions for processing partial recovery claims are in the Medicare Claims Processing Manual, Chapter 29, Coordination with Medigap insurers.

It records as savings, that portion of a partial recovery paid to an attorney or other agent as Medicare's share of the recovery cost. When it refers a case to the RO for recovery action, however, **It does not** record any savings at that point. Savings from a compromise or "subrogation" case may be recorded only **after** a final determination. These cases may not be counted for CPEP credit prior to final settlement.

Totals

In this part of the report (lines 7 and 8), the intermediary reports data on the totals of unpaid claims plus full and partial recoveries.

Line 7 - Claims - The intermediary reports the total number of MSP claims handled during the month.

Line 8 - Dollar Value - The intermediary reports the total dollar value associated with MSP claims during the month.

Pending Claims/Cases

Line 9 - Number - The intermediary reports the number of pending claims/cases as of the close of the reporting month. It includes claims/cases for which "Full Recovery" is expected but all money due has not been received.

Line 10 - Estimated Value - The intermediary reports the gross charges for all claims/cases reported as pending on line 9. Where "Full Recovery or Partial Recovery" has been determined, but all monies have not been received, it reports the gross charges until it receives the full amount due or it is reasonable not to expect further payments.

A case is defined as one or more claims filed on behalf of an individual and related to one specific occurrence that necessitated medical care. When recording data for column 1 concerning WC and Auto Liability, and No Fault Insurance, the intermediary counts only cases. For Working Aged (column iii), ESRD (column iv), and Disabled (column vi), it counts each individual claim.

A case/claim is pending only after it has been developed to the point where it is determined to be an MSP claim and no final resolution has been made. A partial or interim payment is not sufficient to remove a case/claim from the pending rolls. Final resolution occurs when there is no longer a practical expectation of further reimbursement.

Remarks - The intermediary enters any comments relevant to the interpretation and analysis of the report.

Signature - The report is signed by the individual responsible for its compilation.

Date - The intermediary enters the Date that the report is completed and signed.

80.9 - Electronic Submission

(Rev. 6, 08-30-02)
A3-3899.9

A. Keying CMS-1563

- The intermediary uses existing RLINK dialup instructions.

- The intermediary keys the letter "L" to bring up blank CMS-1563.

- The intermediary enters a valid 5 digit intermediary number. It uses the tab key to move from column to column.

- The intermediary enters the reporting period using numeric designation month and year, e.g., 0102 for January 2002.

- The intermediary enters two-position alpha State code.

- The intermediary completes each column of data. Fields with zero need not be keyed. The system will presume all blank fields to be zero.

- The intermediary does not key dollar signs or commas in money fields. It keys only whole dollar amounts.

- After completing the form, the intermediary keys F1. The system will edit and print any error messages on the line above "contractor number." The intermediary tabs to the incorrect field and rekeys a correct entry. When the form passes all edits, the line will read "record has been written." The intermediary keys F4 to return to the menu.

- To abort at any time without writing a record, the intermediary keys F3 and refers to CICS instructions.

- To verify that a report has been written, the intermediary returns to the main menu (F4) and keys "L" to bring up a blank form. It keys in contractor number, reporting period and State code. It keys F7. The completed report appears on the screen.

B. Edits for CMS-1563

- A valid 5-digit intermediary number is required.
- The default value for areas not keyed is zero.
- Appropriate reporting period (MMYY) is required.
- Two-position alpha State code is required.
- Lines 1 + 3 + 5 must equal line 7 for all columns.
- Lines 2 + 4 + 6 must equal line 8 for all columns.
- Line 10 must be equal to or greater than line 9 for all columns unless line 9 is zero. In that case line 10 must also be zero.
- For each line of the report column i must equal the sum of columns ii + iii + iv + v + vi.

90 – Montly Intermediary Part A and Part B Appeals Report (Form CMS-2591)

(Rev. 45, 05-28-04)

At the end of each month, prepare and transmit to CMS a report summarizing activity on Part A reconsiderations, Part A Administrative Law Judge (ALJ) hearings, Part B reviews, and Part B hearings during the month. Complete a separate report for each office assigned a separate intermediary number.

Form CMS-2591 is subject to the Paperwork Reduction Act and requires approval by the Office of Management and Budget (OMB). OMB approval has been requested.

90.1 – Purpose and Scope

(Rev. 45, 05-28-04)

The CMS-2591 (see §3890 - Exhibits 1 thru 6) enables CMS to tabulate data for administrative purposes on the following information:

- The number of reconsiderations, reviews and hearings requested, completed, and pending;
- The number of reconsiderations, reviews and hearings resulting in affirmations or reversals of previous determinations;
- The number of reconsiderations, reviews and hearings involving waiver of liability determinations, and dollar amount of charges allowed;
- Data on timeliness; and
- The number of Part A and Part B reopenings.

90.2 – Due Date

(Rev. 45, 05-28-04)

Transmit the CMS-2591 to CO via PC or terminal. Use instructions in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.

The report is due as soon as possible after the end of the reporting month but no later than the 15th of the month following the end of the reporting month.

100 – Completion of Items on Form CMS-2591
(Rev. 45, 05-28-04)

100.1 – Heading
(Rev. 45, 05-28-04)

Enter your ID number in the space provided. In addition, indicate the reporting month and calendar year, i.e., 1292 for December 1992.

100.2 – Section A – Intermediary Appeal Requests
(Rev. 45, 05-28-04)

This part concerns data from Part A and Part B appeals processes. The number of appeals requested (received), completed, and pending reflects the status of the workload as of the last day of the reporting month. Base data on actual counts of each activity and not on sampling or other estimating techniques.

Appeals fall into the following categories:

1. Part A Reconsideration.--This is the first level of appeal following denial of a Part A claim. It is a re-evaluation of the facts and findings of a claim to determine whether the initial decision was correct. (See §3781.)

Do not count duplicate reconsideration requests or reconsideration requests received before you have made an initial determination on a claim. Do not count telephone requests for reconsiderations or inquiries. Count one reconsideration per request received. With the exception of line 7 of the CMS-2591, do not count the number of claims or beneficiaries involved in the requests.

2. Part B Review.--This is the first formal level of appeal following denial of a Part B claim. It is a second look by a different employee at the claim and supporting evidence. (See §§3792 ff.)

3. Part B Hearing.--This is an independent determination resulting from an appeal of your review decision. This independent determination is rendered by a Hearing Officer (HO) you assigned. The amount in controversy must be at least $100. (See §§3794ff.)

Definition of Columns:

Column (1) TOTAL--All Part A reconsiderations. Column 1 must equal the sum of columns 2, 3 and 4.

Column (2) SNF.--All skilled nursing facility reconsiderations.

Column (3) HHA/HOSPICE.--All home health agency and hospice reconsiderations.

Column (4) OTHER.--All other Part A reconsiderations.

Column (5) PART B REVIEWS.--Count one review per request received (i.e., Form CMS-1964 or equivalent written request). Do not count duplicate review requests or review requests received before you have made an initial determination on a claim. With the exception of line 7 of the CMS-2591, do not count the number of claims or beneficiaries involved in the requests. (Report claim counts in line 7.)

Column (6) PART B HEARINGS.--Count one hearing per request received (i.e., Form CMS-1965 or equivalent written request). Include hearings requested that do not meet the minimum $100 requirements and are subsequently dismissed. With the exception of line 7 of the CMS-2591, do not count the number of claims or beneficiaries involved in the requests. (Report claim counts in line 7.) Do not count hearing requests that qualify for a Part B ALJ hearing. (Part B intermediary hearings are those Part B hearings that a hearing officer adjudicates, as opposed to an ALJ). See definition for Section C.

Do not count requests for HO hearings received after you rendered an on-the-record (OTR) decision in lines 1-44 of the report. Count these cases only in lines 45, 46, 47, 48 and 50 as appropriate.

Line 1. Opening Pending.--Show under columns 1-4, the number of reconsiderations reported on line 19 as the closing pending on the previous month's report. Show under column 5 the number of reviews reported on line 30 as the closing pending on the previous month's report. Show under column 6 the number of hearings reported on line 40 as the closing pending on the previous month's report.

Line 2. Adjustments to Pending.--If it is necessary to revise the pending figure for the close of the previous month because of inventories or reporting errors, enter the adjustment. Report requests received near the end of the reporting month and placed under control in the subsequent month as received in the reporting month, not as requests received in the subsequent month. If some cases were not counted in the proper month's receipts, count them as adjustments to the opening pending in the subsequent month.

If line 3 of the current month differs from the closing pending of the previous month, there must be an entry in line 2 for the current month. Precede the entry by a "+" or "-", as appropriate.

Line 3. Adjusted Pending.--Enter the result of line 1 + line 2 (taking into account the "-" sign, if any).

Line 4. Requests Received.--Show, under the appropriate columns, the number of requests for reconsiderations, reviews, and Part B intermediary hearings received during the reporting month. Include requests transferred to you by other intermediaries if you incur administrative costs for processing the appeals and you report the cost on the Interim Expenditure Report (Form CMS-1523).

If an appellant submits one request involving several different claims (and several different beneficiaries), count it as one request. If an appellant submits more than one request (for different claims) at different times, count each request.

NOTE: See definition of column (6) for instructions on hearings requested subsequent to OTR decisions.

Line 4A. Medical Necessity Documentation Denials.--Show the number of requests included in line 4 that involved initial claim denials for lack of medical documentation.

Line 5. Requests Transferred.--Show under columns 1 thru 5 the number of reconsiderations and review requests you transferred to other contractors because you did not process the original claim(s). Report under column 6 the number of Part B hearing requests transferred to other contractors because the claimant is not within your geographical area (See §3794.3B) or transferred to ROs because the issues are outside the HO's responsibilities. (See §3794.2.) For columns 1-6, if you have reported a reconsideration, review or Part B hearing as transferred, do not report any information regarding it on lines 6-51. The transfer is the final action.

Line 6. Requests Cleared.--Show, under the appropriate columns, the total numbers of reconsiderations, reviews, and Part B hearings completed during the month. Report all completed appeals, regardless if final outcome was affirmation, reversal, withdrawal, or dismissal.

Consider a reconsideration or review cleared when the final determination (EOMB or other notice, including dismissal) is printed or typed, or upon notification of withdrawal by the appellant. In the case of a reversal, consider the case cleared when you initiate the adjustment action.

A Part B hearing may be considered cleared when the decision is signed, or the following conditions exist:

- o The claimant indicates that he/she is satisfied with the On-The-Record (OTR) decision;

- o The claimant indicates after the OTR decision that he/she wishes to proceed with an ALJ hearing (if the amount in controversy is $500 or more);

- o The HO dismisses the hearing request; or

- o The appellant withdraws the hearing request.

Do not consider a hearing completed upon release of an OTR decision unless the appellant specifically requested an OTR hearing. Do not count the OTR hearing as completed until you have completed all follow-up actions as required in §3794.9. If as a result of the follow-up actions, the appellant requests an in-person or telephone hearing after release of the OTR decision, the OTR hearing and decision are not counted on the report with the exception noted below. If the appellant does not appear for the subsequent hearing, dismiss the hearing. (See §3794.3K.) For processing time purposes, the case is completed when you dismiss it; however, the decision to record in lines 9-11 is the OTR decision.

NOTE: If you close a reconsideration, review or hearing after the end of a reporting month but before the report is due on the fifteenth of the subsequent month, do not count it until the subsequent month's report.

Line 7. No. of Claims Involved.--Show on line 6 the total number of claims involved in the appeals reported as cleared during the month. For example, if you process one HHA reconsideration decision which involves five claims, report five claims under column (3), or if you process decisions for two Part B hearings in the month, one of which involved three claims and the other seven, report 10 claims under column (6).

Line 8. Amount in Controversy.--For Part B hearings reported as affirmed (line 9) or reversed (line 11) during the month, show the total dollar amount in controversy on the initial requests. The amount in controversy is the difference between the amount billed (less any reductions required by legislation, e.g., Gramm-Rudman-Hollings) and the amount you originally allowed less any unmet deductible and coinsurance amounts. In effect, the amount in controversy is the amount of payment that the claimant would receive if the denial(s) was fully reversed. Show results rounded to the nearest dollar.

Line 9. Affirmations.--Under the appropriate columns, show the number of completed reconsiderations, reviews, and Part B hearings in which the previous determinations were completely upheld; i.e., no change was made. All parts of all claims in a case must be upheld in order for the case to be counted as an affirmation. An OTR hearing decision does not count as a previous decision if the appellant subsequently requests an in-person or telephone hearing. If the in-person/telephone hearing is dismissed because the appellant did not appear, or the request was withdrawn, use the OTR decision to determine if the case is counted here. (See line 11 for partial affirmations. Do not include them here.)

If you uphold your original determination, but pay under limitation of liability, count the determination as an affirmation. Report the appropriate information in Section D of the CMS-2591.

Line 10. Dism./Withdr.--Report, under the appropriate column, the number of completed reconsiderations, reviews, and Part B hearings that were withdrawn by the appellant or dismissed (before determination) by you or the HO. Report here and in lines 4 and 6 an appeal that is requested and withdrawn or dismissed within the same month. If the appellant requests an in-person or telephone hearing after receiving an OTR decision, and you dismiss the hearing because the appellant failed to appear, the OTR decision is the final decision, not the dismissal. Similarly, for a withdrawal, use the OTR decision.

A dismissal at the reconsideration or review level is done when written correspondence has been identified as an appeal request, but the claimant does not have the right to an appeal. Misrouted correspondence and duplicate requests are not dismissals.

If you have incorrectly counted such correspondence as an appeal on a previous report, use line 2 (adjustments to pending) to correct the count. Do not count a duplicate request for appeal anywhere on the report. Likewise, do not count on the report a request for appeal received before an initial claim determination has been rendered. (Consider the request an inquiry.)

Line 11. Reversals (Full or Part).--Under the appropriate columns, show the total number of completed reconsiderations, reviews, and Part B hearings in which at least part of the prior determination was reversed. That is, a change was made and some or all of the new determination was in favor of the appellant.

If a reconsideration, review, or Part B hearing involves several claims, and the initial determinations for some are affirmed and some are reversed, consider the decision a reversal. An OTR hearing decision does not count as a previous decision if the appellant subsequently requests an in-person or telephone hearing. If the in-person/telephone hearing is dismissed because the appellant did not appear, or the request was withdrawn, use the OTR decision to determine if the case is counted here.

Line 12. Amount Awarded.--For cases included in line 11, show the amount of submitted charges for services where the determination was reversed. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

Processing and Pending Times.--This deals with processing and pending times for Part A and Part B appeals.

Computing Time to Process Part A Reconsiderations and Part B Reviews for (Lines 13-18 and 25-29)

For lines 13-18 and 25-29, use the matrix below to determine the number of days from receipt to completion of reconsiderations and reviews. The date of receipt in all cases is the day the processing contractor received it in its corporate mailroom.

Situation	**Date Completed**
• The appellant withdraws the request.	The date you were notified of the withdrawal.
• You dismiss the request or affirm the original determination.	The date of the notice.
• You process the request to a reversal.	The date when you submit the claim to CWF if payment can be made without further development, or when you initiate development; e.g., when you must ascertain whether or not the provider has refunded payment to the beneficiary.

Computing Time to Process Part B Hearings for Lines 35-39

For lines 35-39, use the matrix below to determine the number of days from receipt to completion of Part B hearings. The date of receipt, in all cases, is the day you receive the appeal request in its corporate mailroom. In out-of-area cases, it is the date that the second intermediary receives the request.

Situation	**Date Completed**

An OTR decision is made and the appellant accepts the decision or decided to go directly to an ALJ hearing.	The date of the OTR decision.
An OTR decision is made and the appellant chooses in a timely fashion to proceed with the in-person or telephone hearing.	The date of the second decision. If the appellant appears, and you dismiss the hearing, use the date of notice of dismissal.
An in-person or telephone hearing is held without an OTR decision.	The date of the decision.
The appellant withdraws the hearing request.	The date you are notified of the withdrawal.
The HO dismisses the hearing request.	The date of the dismissal notice.

RECONSIDERATIONS

Line 13. Processing Time - Average.--Report under the appropriate columns the average number of days from receipt of the reconsideration to the date of completion.

To compute the average number of days from request to completion, divide the total days elapsed for all requests cleared in the month by the number of requests cleared. Round results to the nearest day. Calculate the days elapsed for an individual request by subtracting the Julian date of receipt from the Julian date of completion. If the request is cleared in the year following the year of receipt, add 365 or 366 to the result, as appropriate. (Otherwise, you will get a negative number.) If a case is cleared the same day it is received, consider it to require 1 day.

NOTE: Include all cases cleared, regardless of whether they were affirmed, reversed, dismissed, or withdrawn.

Line 14. Reconsiderations Completed 1-45 Days.--Show the number of reconsiderations that required 1-45 days, to complete. If a case is cleared the same day it is received, consider it to require 1 day.

Line 15. Reconsiderations Completed 46-60 Days.--Show the number of reconsiderations that required 46-60 days to complete.

Line 16. Reconsiderations Completed 61-90 Days.--Show the number of reconsiderations that required 61-90 days to complete.

Line 17. Reconsiderations Completed 91-120 Days.--Show the number of reconsiderations that required 91-120 days to complete.

Line 18. Reconsiderations Completed over 120 Days.--Show the number of reconsiderations that required more than 120 days to complete.

Line 19. Closing Pending Reconsiderations.--Show, under the appropriate columns, the total number of reconsiderations that have not been completed by the end of the reporting month.

Line 20. Reconsiderations Pending 1-45 Days.--Show the number of reconsiderations included in line 19 that have been pending 1-45 days, inclusive, at the end of the reporting month.

Line 21. Reconsiderations Pending 46-60 Days.--Show the number of reconsiderations included in line 19 that have been pending 46-60 days, inclusive, at the end of the reporting month.

Line 22. Reconsiderations Pending 61-90 Days.--Show the number of reconsiderations included in line 19 that have been pending 61-90 days, inclusive, at the end of the reporting month.

Line 23. Reconsiderations Pending 91-120 Days.--Show the number of reconsiderations included in line 19 which have been pending 91-120 days, inclusive, at the end of the reporting month.

Line 24. Reconsiderations Pending Over 120 Days.--Show the number of reconsiderations included in line 19 which have been pending more than 120 days at the end of the reporting month.

REVIEWS

Line 25. Processing Time - Average.--Report here the average number of days from the receipt of the review to the date of completion.

To compute the average number of days from request to completion, divide the total days elapsed for all requests cleared in the month by the number of requests cleared. Round results to the nearest day. Calculate the days elapsed for an individual request by subtracting the Julian date of receipt from the Julian date of completion.

If the request is cleared in the year following the year of receipt, add 365 or 366 to the result, as appropriate. (Otherwise, you will get a negative number.) If a case is cleared the same day it is received, consider it to require 1 day.

NOTE: Include all cases cleared, regardless of whether they were affirmed, reversed, dismissed, or withdrawn.

Line 26. Reviews Completed in 1-30 Days.--Show the number of cases that required 1-30 days to complete. If a case is cleared the same day it is received, consider it to require 1 day.

Line 27. Reviews Completed in 31-45 Days.--Show the number of reviews that required 31-45 days to complete.

Line 28. Reviews Completed in 46-60 Days.--Show the number of reviews that required 46-60 days to complete.

Line 29. Reviews Completed in 61+ Days.--Show the number of reviews that required more than 60 days to complete.

Line 30. Closing Pending-Reviews.--Show the total number of reviews that have not been completed by the end of the reporting month.

Line 31. Reviews Pending 1-30 Days.--Show the number of reviews included in line 30 that have been pending 1-30 days, inclusive, at the end of the reporting month.

Line 32. Reviews Pending 31-45 Days.--Show the number of reviews included in line 30 that have been pending 31-45 days, inclusive, at the end of the reporting month.

Line 33. Reviews Pending 46-60 Days.--Show the number of reviews included in line 30 that have been pending 46-60 days, inclusive, at the end of the reporting month.

Line 34. Reviews Pending Over 60 Days.--Show the number of reviews included in line 30 that have been pending more than 60 days at the end of the reporting month.

PART B HEARINGS

Line 35. Hearing Processing Time - Average.--Report the average number of days from receipt of the hearing request to date of completion. See methodology under line 25.

Line 36. Hearings Completed in 60 Days.--Show the number of hearings that required 1-60 days to complete. If a case is cleared the same day it is received, consider it to require 1 day.

Line 37. Hearings Completed in 61-90 Days.--Show the number of hearings that required 61-90 days to complete.

Line 38. Hearings Completed 91-120 Days.--Show the number of hearings that required 91-120 days to complete.

Line 39. Hearings Completed Over 120 Days.--Show the number of hearings that required more than 120 days to complete.

Line 40. Closing Pending-Hearings.--Show the total number of hearings that have not been completed by the end of the reporting month. You may not consider a hearing completed upon release of an OTR decision unless the appellant specifically requested an OTR hearing. See definition for line 6.

Line 41. Hearings Pending 1-60 Days.--Show the number of hearings included in line 40 that have been pending 1-60 days, inclusive, at the end of the reporting month.

Line 42. Hearings Pending 61-90 Days.--Show the number of hearings included in line 40 which have been pending 61-90 days, inclusive, at the end of the reporting month.

Line 43. Hearings Pending 91-120 Days.--Show the number of hearings included in line 40 which have been pending 91-120 days, inclusive, at the end of the reporting month.

Line 44. Hearings Pending Over 120 Days.--Show the number of hearings included in line 40 that have been pending more than 120 days at the end of the reporting month.

100.3 – Section B – Part B Hearing Results

(Rev. 45, 05-28-04)

Section B deals with data on Part B hearings completed during the month. Base data shown on actual counts of each activity and not derived from sampling or other estimating techniques.

HEARINGS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) On-the-Record with No Subsequent Hearing.--Include in column 1 hearings held where the appellant originally requested an OTR hearing, indicates that he/she is satisfied with the OTR decision, that he/she wishes to proceed with an ALJ hearing (if the amount in controversy is $500 or more), or fails to respond to the OTR within the required time frame. In addition, if the appellant requests an in-person or telephone hearing subsequent to an OTR decision, but the hearing is dismissed or withdrawn, include it here and not in columns (2) or (3).

Column (2) All Telephone.--Include in column 2, hearings where the appellant requested and had a telephone hearing subsequent to an OTR hearing decision, or a telephone hearing was held without a prior OTR decision. Count all telephone hearings including those where the appellant did not follow-up timely to the OTR notice, but later requested a telephone hearing.

Column (3) All In-Person.--Include in column 3 hearings where the appellant requested and had an in-person hearing subsequent to an OTR hearing decision, or an in-person hearing was held without a prior OTR decision. Count all in-person hearings including those where the appellant did not follow-up timely to the OTR notice but later requested an in-person hearing.

Column (4) Number in 120 Days.--For the total cases included in line 47, columns 2 and 3, (e.g., the sum) show for lines 49-51 the numbers that were completed within 120 days of receipt. Use the methodology shown above the explanation for line 13 to determine the completion date. Where an OTR decision is made and the appellant chooses to not follow-up timely and later requests either an in-person or telephone hearing, completion time for this second reported hearing is measured from the date of receipt of original request to the date of the second decision. If the appellant does not appear, dismiss the hearing in accordance with §3794.3k, and use the date of notice of dismissal as your date completed.

Line 45. Reversals.--Under the appropriate columns, show the number of OTR, telephone, and in-person hearings completed in the month in which at least part of the review determination was reversed i.e., a change was made and some, or all, of the new determination was in favor of the appellant. (See the definition for line 11.)

Line 46. Affirmations.--Under the appropriate columns, show the number of OTR, telephone, and in-person hearings completed in the month in which the review determination was completely upheld, i.e., no change was made. All parts of all claims must be upheld in order for the case to be counted as an affirmation. (See the definition for line 9.)

Line 47. Total Decisions.--Show the total number of hearing decisions completed during the month that resulted in a reversal or affirmation, excluding dismissals and withdrawals.

Line 48. Number in 120 Days.--For cases included in line 47, show the number that were completed within 120 days of receipt. See methodology for column 4 to determine the completion date.

Line 49. No Previous OTR Held.--For cases included in line 47, columns (2) and (3), report the number where you held the telephone or in-person hearing without first making an OTR decision, i.e., the OTR hearing was bypassed.

In column (4), report the number of cases included in either column (2) or (3) which were completed within 120 days.

Line 50. Previous OTR Counted.--For the cases included in line 47, columns (2) and (3), report the number where you included the OTR count on a previous report. In column (4), report the number of cases included in either column (2) or (3) that were completed within 120 days.

Cases reported in line 50 are those where an OTR decision was made and the appellant either accepted the OTR decision, did not respond timely, or decided to go directly from the OTR decision to an ALJ hearing. Then, subsequent to this OTR decision "acceptance," the appellant changed his/her mind and decided that he/she wanted a telephone or in-person hearing. Do not include these cases in line 6.

Line 51. Previous OTR Not Counted.--For cases included in line 47, columns (2) and (3), report the number where you did not include the OTR count on a previous report. These are cases where you made the OTR decision first, and the appellant indicated in a timely fashion (see §3794.9) that he/she wanted a telephone or in-person hearing. In column (4), report the number of cases included in either column (2) or (3) that were completed within 120 days.

100.4 – Section C – Part A and Part B ALJ Hearings

(Rev. 45, 05-28-04)

Use Section C to report requests for ALJ hearings, including those expected to be dismissed for failure to meet the amount in controversy requirement or for any other reason, such as the lack of a fair hearing in Part B cases.

ALJ HEARINGS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) TOTAL.--All Part A ALJ hearing requests as originally filed.
Column 1 must equal the sum of columns 2, 3 and 4.

Column (2) SNF.--All skilled nursing facility (SNF) hearings.

Column (3) HHA/HOSPICE.--All home health agency (HHA) and hospice hearings.

Column (4) OTHER.--All other hearings.

Column (5) PART B.--All Part B ALJ hearings.

Line 52. Opening Pending.--Show the number of ALJ hearings reported on Line 67 as the closing pending on the previous month's report.

Line 53. Adjustments to Pending.--See definition for line 2. If line 54 of the current month differs from data in line 67 of the previous month, there must be an entry in line 53 for the current month. Precede the entry by a "+" or "-" as appropriate.

Line 54. Adjusted Pending.--Show the result of line 52 + line 53 (taking into account the "-" sign, if any).

Line 55. Requests Received.--Show the number of ALJ hearings requested during the month. (See §3797)

Line 56. Requests Forwarded to ALJ.--Show the number of ALJ hearing requests forwarded to ALJs during the month. Consider the case forwarded when all necessary material has been mailed to the ALJ.

Line 57. No. of Claims Involved.--Show the number of claims involved in the ALJ hearing requests forwarded to ALJs as reported on line 56.

Line 58. In 1-7 Calendar Days.--Show the number of ALJ hearing requests forwarded to ALJs within 7 calendar days from receipt of the request in the corporate mailroom to mailing of the necessary information. Show data for all cases mailed during the month. The number must be less than, or equal to, the number shown in line 56.

Line 59. In 1-14 Calendar Days.--Show the number of ALJ hearing requests forwarded to ALJs within 14 calendar days from receipt of the request in the corporate mailroom to mailing of the necessary information to the ALJ. Show data for all cases mailed during the month. Note that the number in this line must be less than or equal to the number shown in line 56.

Line 60. Average Time to Forward.--Report the average number of calendar days from receipt of the ALJ request to the date of mailing of the necessary information. Use the methodology discussed in §3888.2 for line 13.

Line 61. Completed.--Show the number of ALJ hearing requests completed during the month. Consider a case completed when you have received the completed decision from the ALJ for all parts of the case.

Line 62. Amount in Controversy.--For ALJ hearings reported as affirmed (line 63) or reversed (line 65), during the month, show the total dollar amount in controversy according to the initial ALJ hearing request. This should be the amount remaining after previous appeals decisions. Round results to the nearest dollar.

Line 63. Affirmations.--Show the number of completed ALJ hearings in which the previous determination was completely upheld, i.e., no change was made. All parts of all claims in a case must be upheld in order for the case to be counted as an affirmation. See line 65 for partial affirmations. (Do not include partial affirmations on this line.)

If the prior determination was upheld, but payment was made under limitation of liability, count the ALJ hearing determination as an affirmation. Report the appropriate information in lines 77 and 78.

Line 64.   Dismissals/Withdrawals.--Show the number of completed hearings that were withdrawn by the appellant or dismissed (before determination) by the ALJ. Report an appeal that was requested and withdrawn or dismissed within the same month here and in lines 55, 56, and 61.

Line 65.   Reversals (Full or Part).--Show the total number of completed ALJ hearings in which at least part of the prior determination was reversed; i.e., a change was made and some or all of the new determination was in favor of the appellant. For example, if an ALJ hearing involved several claims, and the initial determinations for some were affirmed and some were reversed, consider the decision to be a reversal.

Line 66.   Amount Awarded.--For cases included in line 65, show the amount of submitted charges for services where the determination was reversed. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

Line 67.   Closing Pending.--Show the total number of ALJ hearing requests that were not completed by the end of the reporting month. Consider a case transferred to an ALJ as pending until you have received the completed decision from the ALJ for all parts of the case.

ALJ DISPOSITIONS

Line 68.   Number of Dispositions.--Report the number of dispositions rendered by the ALJ(s) in cases reported as cleared for the month in Line 61. There will usually be more ALJ dispositions than cases counted in line 61. Do not count a case in line 61 until the ALJ has cleared all of the claims included in the request for hearing.

EXAMPLE: You forwarded one request to an ALJ involving 20 claims. The ALJ dismisses 10 claims at once. A month later, the ALJ decides to affirm the original decision on 5 others as one group. The other five claims receive separate determinations. This would be counted as seven dispositions.

Line 69.   Affirmations.--Of those dispositions shown in line 68, report the number of decisions rendered by the ALJ(s) that were completely upheld.

Line 70.   Dismissals/Withdrawals.--Of those dispositions shown in line 68, report the number of dismissals and withdrawals issued by the ALJ(s).

Line 71.   Reversals.--Of those dispositions shown in line 68, report the number of decisions rendered by the ALJ (s) in which at least part of the prior determination was reversed.

EFFECTUATION OF ALJ DECISIONS

Line 72.   Total Effectuations.--Show the number of ALJ hearing decisions for which you initiated effectuation during the month. Consider effectuation of a decision to be initiated when you:

- Submit the claim to CWF if payment can be made without further development; or

- o Initiate development, e.g., when you must determine whether or not the provider has refunded payment to the beneficiary.

Line 73. Number 1-7 Days.--Show the number of cases where you effectuated the decision within 7 days. Effectuation days include day of receipt of the decision in your corporate mailroom.

Line 74. Number 8-15 Days.--Show the number of cases where you effectuated the decision within 8-15 days.

Line 75. Number 16-30 Days.--Show the number of cases where you effectuated the decision within 16-30 days.

Line 76. Number Over 30 Days.--Show the number of cases where you effectuated the decision in more than 30 days.

LIMITATION OF LIABILITY DETERMINATION IN ALJ CASES

Line 77. No. Waived - Ben. and Prov..--Show the number of claims in ALJ hearings during the reporting month where the liability of both the beneficiary and provider was limited.

Line 78. Amount Awarded.--For claims included in line 77, show the amount of the submitted charges for services where the liability was limited (including non-covered services where the liability of the beneficiary and provider are limited.) Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

100.5 – Section D – Limitation of Liability
(Rev. 45, 05-28-04)

Section D concerns requests involving limitation of liability determinations in Part A reconsiderations, Part B reviews and Part B hearings. To include a claim in lines 79-82, you must have originally denied it or reduced it for medical necessity or custodial care reasons.

Lines 80-82 are mutually exclusive; i.e., a claim meeting the above conditions may be counted on only one of three lines. Therefore, ensure that the sum of the number of the claims recorded on each of these lines equals the total number of claims considered for limitation of liability during the period as reported on line 79.

The counts in lines 79-82 reflect counts of claims. Report cases corresponding to the claims counted in Section A, as appropriate. If a claim is considered for limitation of liability at the initial claim level, do not count it at the review or hearing level unless you change the limitation of liability decision.
Categorize claims for the columns shown in Section D according to the adjudication level at which limitation of liability is considered or granted.

If you make several different limitation of liability decisions on the same claim, use the highest numbered line (out of 80-82) on the report that applies to that claim. Count the claim only once.

For example, if you waive both the beneficiary and provider liability on any part of the claim, count the claim on line 82.

Line 79. Total Number Considered.--Show, under the appropriate columns, the number of claims, meeting the conditions above, for which limitation of liability was considered during the month.

Line 80. No. Considered - Not Waived.--Show, under the appropriate columns the number of claims that meet the conditions above, on which limitation of liability was considered, but was not granted to the beneficiary. This also includes cases where only provider liability is waived.

Line 81. No. Waived - Ben. Only.--Show, under the appropriate columns, the numbers of claims that meet the conditions above, where the liability of only the beneficiary was limited.

Line 82. No. Waived - Ben. and Prov.--Show, under the appropriate columns, the numbers of claims where the liability of both the beneficiary and provider was limited.

Line 83. Amount Awarded.--For cases included in line 82, show the amount of the submitted charges for services where liability was limited (including noncovered services where liability of the beneficiary and provider are limited). Show charges prior to application of the deductible and coinsurance. Round results to nearest dollar.

100.6 – Section E – Part A and Part B Reopenings

(Rev. 45, 05-28-04)

Report the number of Part A and Part B claims involved in reopenings completed during the month. See §3795 for discussion of what constitutes a reopening. Include reopenings which do not result in revisions. Claims review, reconsideration, Part B hearings, and ALJ hearings undertaken as part of the appeal process are not reopenings.

PART A REOPENINGS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) Total.--All reopenings completed.

Column (2) Pre-Recon.--All reopenings of initial claim determinations. If a claim has been through a reconsideration, do not count it here.

Column (3) Post-Recon.--All reopenings of reconsideration determinations. If a claim has been through any type of hearing, do not count it here.

Column (4) Post-ALJ Hearing.--All reopenings of ALJ hearing determinations. Once a claim has been through an ALJ hearing, count it here if it is reopened.

Line 84. Total Number.--Show the number of claims in which the reopening of a claim, reconsideration, or hearing determination was completed, whether or not the determination was revised.

Line 85. Unfavorable to Claimant.--Of the claims shown in line 84, show the number which resulted in a revision of a previously favorable decision.

Line 86. No Change.--Of the claims shown in line 84, show the number of claims that you reopened, but on which you did not change the initial determination.

Line 87. Favorable to Claimant.--Of the claims shown in line 84, show the number which resulted in a favorable revision of a previously unfavorable decision.

Line 88. Amount Awarded.--For cases included in line 87, show the amount of the submitted charges for services which involved a revision of a previously unfavorable decision. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

PART B REOPENINGS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) Total.--All reopenings completed.

Column (2) Pre-Review.--All reopenings of initial claim determinations. If a claim has been through a review, or any type of hearing, do not count it here.

Column (3) Post-Review.--All reopenings of review determinations. If a claim has been through any type of hearing, do not count it here.

Column (4) Post-Hearing.--All reopenings of hearing determinations, regardless of the type of hearing; e.g., intermediary HO or ALJ. Once a claim has been through a hearing, count it here if it is reopened.

Line 89. Total Number.--Show the number of claims in which the reopening of a claim, review or hearing determination was completed, whether or not the determination was revised.

Line 90. Unfavorable to Claimant.--Of the claims shown in lines 89, show the number which resulted in an unfavorable revision of a previously favorable decision.

Line 91. No Change.--Of the claims shown in line 89, show the number of claims that you reopened, but on which you did not change the initial determination.

Line 92. Favorable to Claimant.--Of the claims shown in line 89, show the number which resulted in a favorable revision of a previously unfavorable decision.

Line 93. Amount Awarded.--For cases included in line 92, show the amount of the submitted charges for services that involved a revision of a previously unfavorable decision. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

110 – Checking Reports

(Rev. 45, 05-28-04)

Before you send the report to CMS, check for completeness and arithmetical accuracy. Use the following checklist for an arithmetical check for each column:

- Column 1 = Column 2 + Column 3 + Column 4 for lines 1-7, 9-12, 14-24, 52-59, and 61-93.
- Line 1 for columns 1-4 must be equal to line 19 of the previous month.
- Line 1 Column 5 must be equal to line 30 of the previous month.
- Line 1 Column 6 must be equal to line 40 of the previous month.
- Line 1 + line 2 = line 3.
- Line 3 + line 4 - line 5 - line 6 = line 19 for columns 1-4.
- Line 3 + line 4 - line 5 - line 6 for column 5 = line 30.
- Line 3 + line 4 - line 5 - line 6 for column 6 = line 40.
- Line 4A must be less than or equal to line 4.
- Line 6 = line 9 + line 10 + line 11.
- Line 6 = line 14 + line 15 + line 16 + line 17 + line 18 for column 1-4.
- Line 6, column 5 = line 26 + line 27 + line 28 + line 29.
- Line 6, column 6 = line 36 + line 37 + line 38 + line 39.
- Line 7 must be greater than or equal to line 6.
- Line 9 + line 11 for column 6 must be less than or equal to the sum of columns 1, 2, and 3 for line 47.
- Line 19 = line 20 + line 21 + line 22 + line 23 + line 24.
- Line 30 = line 31 + line 32 + line 33 + line 34.
- Line 40 = line 41 + line 42 + line 43 + line 44.
- Line 47 = line 45 + line 46 for columns 1-3.
- Line 47 = line 49 + line 50 + line 51 for columns 2 and 3 only.
- Line 48 must be less than or equal to line 47 for columns 1, 2, and 3.
- Line 49 (column 4) must be less than or equal to line 49 (column 2) + line 49 (column 3).
- Line 50 (column 4) must be less than or equal to the sum of line 50 (column 2) + line 50 (column 3).

- Line 51 (column 4) must be less than or equal to the sum of line 51 (column 2) + line 51 (column 3).

- Line 52 must be equal to line 67 of the previous month.

- Line 54 = line 52 + line 53.

- Line 54 + line 55 - line 61 = line 67.

- Line 57 must be greater than or equal to line 56.

- Line 58 must be less than or equal to line 56.

- Line 59 must be less than or equal to line 56.

- Line 59 must be greater than or equal to line 58.

- Line 61 = line 63 + line 64 + line 65.

- Line 62 must be greater than or equal to 500 times the sum of lines 63 and 65 in Column (5) only (each case must involve at least $500 per case).

- Line 66 must be greater than or equal to line 65 (must award at least $1 per case).

- Line 68 = line 69 + line 70 + line 71.

- Line 72 = line 73 + line 74 + line 75 + line 76.

- Line 78 = must be greater than or equal to line 77 (at least $1 per claim).

- Line 79 = line 80 + line 81 + line 82.

- Line 83, must be greater than or equal to line 82 (at least $1 per claim).

- Line 84 = line 85 + line 86 + line 87.

- Line 88 must be greater than or equal to line 87 (at least $1 per claim).

- Line 89 = line 90 + line 91 + line 92.

- Line 93 must be greater than or equal to line 92 (at least $1 per claim).

Public reporting burden for this collection of information is estimated to average 2 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to Office of Financial Management, CMS, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project Washington, DC 20503.

110.1 – Exhibit 1

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 1.

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	**REPORTING PERIOD**					
	PART A RECONSIDERATIONS				**PART B**	
A. INTERMEDIARY APPEAL REQUESTS	**TOTAL (1)**	**SNF (2)**	**HHA/ HOSPICE (3)**	**OTHER (4)**	**REVIEWS (5)**	**HEARINGS (6)**
1. OPENING PENDING						
2. ADJUSTMENTS TO PENDING						
3. ADJUSTED PENDING						
4. REQUESTS RECEIVED						
4A. MED. NEC. DOC. DENIALS						
5. REQUESTS TRANSFERRED						
6. REQUESTS CLEARED						
7. NO. OF CLAIMS INVOLVED						
8. AMOUNT IN CONTROVERSY						
9. AFFIRMATIONS						
10. DISMISSAL/WITHDRAWALS						
11. REVERSALS (FULL OR PART)						
12. AMOUNT AWARDED						

Form CMS-2591 Screen 1

110.2 – Exhibit 2

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 2.

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	**REPORTING PERIOD**			
	PART A RECONSIDERATIONS			
A. INTERMEDIARY APPEAL REQUESTS	**TOTAL**	**SNF**	**HHA/HOSPICE**	**OTHER**
	(1)	**(2)**	**(3)**	**(4)**
PROCESSING TIMES				
13. AVERAGE				
14. NO. COMPLETED 1-45 DAYS				
15. NO. COMPLETED 46-60 DAYS				
16. NO. COMPLETED 61-90 DAYS				
17. NO. COMPLETED 91-120 DAYS				
18. NO. COMPLETED OVER 120 DAYS				
PENDING TIMES				
19. CLOSING PENDING				
20. NO. PENDING 1-45 DAYS				
21. NO. PENDING 46-60 DAYS				
22. NO. PENDING 61-90 DAYS				
23. NO. PENDING 91-120 DAYS				

24. NO. PENDING OVER 120 DAYS				

Form CMS-2591 Screen 2

110.3 – Exhibit 3

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 3

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	**REPORTING PERIOD**				
A. INTERMEDIARY APPEAL REQUESTS REVIEWS	**PART B APPEALS**				
	Reviews			**Hearings**	
	(1)	**HEARINGS**		**(2)**	
PROCESSING TIMES		PROCESSING TIMES			
25. AVERAGE		35. AVERAGE			
26. NO. 1-30 DAYS		36. NO. 1-60 DAYS			
27. NO. 31-45 DAYS		37. NO. 61-90 DAYS			
28. NO. 46-60 DAYS		38. NO. 91-120 DAYS			
29. NO. OVER 60 DAYS		39. NO. OVER 120 DAYS			
PENDING TIMES		PENDING TIMES			
30. CLOSING PENDING		40. AVERAGE			
31. NO. 1-30 DAYS		41. NO. 1-60 DAYS			
32. NO. 31-45 DAYS		42. NO. 61-90 DAYS			
33. NO. 46-60 DAYS		43. NO. 91-120 DAYS			
34. NO. OVER 60 DAYS		44. NO. OVER 120 DAYS			
B. PART B	**OTR**	**All**	**All**	**Number**	

HEARING RESULTS	With No Subsequent (1)	Telephone Hearings (2)	In-Person Hearings (3)	In 120 Days (4)
45. REVERSALS				
46. AFFIRMATIONS				
47. TOTAL DECISIONS				
48. NBR IN 120 DAYS				
49. NO PREV. OTR HELD				
50. PREV. OTR COUNTED				
51. PREV. OTR NOT CNTD				

Form CMS-2591 Screen 3

110.4 – Exhibit 4
(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 4

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	REPORT PERIOD				
C. PART A AND B ALJ HEARINGS	**PART A**				
	Total (1)	**SNF (2)**	**HHA/Hospice (3)**	**Other (4)**	**Part B (5)**
52. OPENING PENDING					
53. ADJUSTMENTS TO PENDING					
54. ADJUSTED OPENING PENDING					
55. REQUESTS RECEIVED					

56. REQUESTS FRWD. TO ALJ					
57. NO. OF CLAIMS INVOLVED					
58. NO. IN 7 CALENDAR DAYS					
59. NO. IN 14 CALENDR DAYS					
60. AVG. TIME TO FORWARD					
61. COMPLETED					
62. AMT. IN CONTROVERSY					
63. AFFIRMATIONS					
64. DISMISSALS/WITHDRAWALS					
65. REVERSALS (FULL/PART)					
66. AMOUNT AWARDED					
67. CLOSING PENDING					

Form CMS-2591 Screen 4

110.5 – Exhibit 5

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 5

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	**REPORT PERIOD**				
	PART A				**PART B (5)**
C. PART A AND B ALJ HEARINGS	**Total (1)**	**SNF (2)**	**HHA/Hospice (3)**	**Other (4)**	

DISPOSITIONS					
68. NUMBER OF DISPOSITIONS					
69. AFFIRMATIONS					
70. DISMISSALS/WITHDRAWALS					
71. REVERSALS (FULL OR PART)					
EFFECTUATIONS					
72. TOTAL EFFECTUATIONS					
73. NO. 1-7 DAYS					
74. NO. 8-15 DAYS					
75. NO. 16-30 DAYS					
76. NO. OVER 30 DAYS					
LIMITATION OF LIABILITY					
77. WAIVED - BEN & PROV.					
78. AMOUNT AWARDED					

D. LIMITATION OF LIABILITY (CLAIM COUNTS)	**PART A RECONSIDERATIONS**				**PART B**	
	Total (1)	**SNF (2)**	**HHA/ Hospice (3)**	**Other (4)**	**Reviews (5)**	**Hearings (6)**
79. TOTAL NUMBER CONSIDERED						
80. CONSIDERED - NOT WAIVED						
81. WAIVED - BEN. ONLY						
82. WAIVED - BEN. & PROV.						

83. AMOUNT AWARDED						

Form CMS-2591 Screen 5

110.6 - Exhibit 6
(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 6

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	**REPORT PERIOD**			
E. REOPENINGS (Claims Count) PART A	**TOTAL (1)**	**PRE-Recon (2)**	**Post-Recon (3)**	**Post-ALJ Hearing (4)**
84. TOTAL				
85. UNFAVORABLE TO CLAIMANT				
86. NO CHANGE				
87. FAVORABLE TO CLAIMANT				
88. AMOUNT AWARDED				
PART B	**TOTAL**	**Pre-Review**	**Post-Review**	**Post-Hearing**
89. TOTAL				
90. UNFAVORABLE TO CLAIMANT				
91. NO CHANGE				
92. FAVORABLE TO CLAIMANT				
93. AMOUNT AWARDED				

Form CMS-2591 Screen 6

120 - Completing Page One of the Carrier Performance Report

(Rev. 6, 08-30-02)
B3-13301

120.1 - Classification of Claims for Counting

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

All claims data entered on page one of the performance report must represent counts of claims (real and replicate) as defined in the Medicare Claims Processing, Chapter 1, General Billing Requirements. The carrier includes in column (i) the following types of claims: CMS-1500s, CMS-1490s, and CMS-1491s. Of these claims forms, it reports the assigned in column (ii) and the unassigned in column (iii).

It includes any claims where processing has been suspended due to CMS directives since they are still part of its claims workload.

NOTE: It does not count assigned claims received from physicians/suppliers if they are incomplete, incorrect, or inconsistent and consequently returned for clarification. It does not have to control such claims.

Throughout its process, it includes the date material is received on all claims (real and replicate). It shows identifying numbers or codes on all replicate claims through the processing system so that they can be counted and reported separately in Part A.

The carrier reports claims as received in the month the claim is received in its mailroom with the following exceptions:

- Additional real claims resulting from a split; and
- Claims identified as replicates.

Split and replicate claims, although carrying the dates the materials were originally received, are to be counted as receipts for the month in which they are **recognized by the carrier's system** as created (i.e., split or identified as replicate) for purposes of this report.

EXAMPLE: The carrier splits a claim received in the reporting month into two claims because the total number of line items exceeds its system's line item limitation. If it can recognize this split when it occurs, it reports two claims in "Total Claims Received During Month" and in "Net Number of Claims Received" (lines 4 and 6, respectively) in Part A of the report. It reports both claims in Part A. After processing the split (replicate) claim, it reports it in Part A under "Replicate Claims Processed" (line 16), as well as under "Total Claims Processed" (line 15). If its system does not indicate when the split occurs, it counts the new claim as a receipt for the month in which the system allows it to be recognized, although the date claims materials were originally received must be carried forward and remain unchanged.

The carrier counts claims received near the end of the reporting month but placed under computer control in the following month as received in the reporting month. It obtains this count by a physical inventory or by computer count.

130 - Completion of Items on Page One of Form CMS-1565

(Rev. 6, 08-30-02)
B3-13302

130.1 - Heading

(Rev. 6, 08-30-02)
B3-13302.1

This report is referenced as Form B in the CROWD system. The carrier completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen. It first keys in the number of working days scheduled for the reporting period, less any days where no claims were processed as a result of a strike, snow storm, etc. It does not count Saturdays, Sundays, or holidays.

130.2 - Part A - Monthly Workload Operations

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

This part of the report presents data on carrier claims processing activity during the reporting period. Counts of claims (real and replicate) processed, total claims (real and replicate) pending, or pending from prior months must reflect the actual status of claims (real or replicate) workloads as of the last day of the reporting calendar month. Data shown must be based on reliable counts of all claims (real or replicate) processing activity and the entire "in-house" pending workload. This data may not be derived from estimates.

If a single claim is split into two or more real claims, or into one real claim and one or more replicate claims, the carrier considers each split (real and replicate) as a separate, distinct claim for purposes of counting claims. The original real claim is a receipt for the month in which it was received. It counts a claim split from the original, or identified as a replicate, as a receipt for the month in which it is actually created or in which its system recognizes it as a separate claim. To determine the age of pending claims, the carrier considers the receipt date as the date the original claim was received and not the date it was split from another claim.

It reports, in Part A, only data relating to initial claims (real and replicate) actions. It does not report data on requests for, or dispositions of, reviews, hearings, or reopenings of initial claim actions.

Opening Pending

Line 1. Claims Pending End of Last Month - The system will pre-fill the number pending from line 17 on the previous month's report.

Line 2. Adjustments - If it is necessary to revise the pending figure for the close of the previous month, the carrier enters the adjustment, preceded by a minus sign for negative adjustments, as appropriate. Adjustments normally result from:

- Private claims incorrectly counted as Medicare claims;
- Beneficiary inquiries or other correspondence incorrectly counted as Medicare claims; and

- Claims consisting of one or more continuation forms incorrectly counted as more than one Medicare claim.

The carrier reports claims received near the end of the reporting month, and placed under computer control sometime after the reporting month, as claims received in the reporting month. It does not count them as claims received in the following month. If some claims have not been counted in the proper month's receipts, it counts them as adjustments to the opening pending in the subsequent month.

Line 3. Adjusted Opening Pending - The system will sum line 1 + line 2 to calculate the adjusted opening pending.

Receipts

Line 4. Total Claims Received During Month - The carrier enters all real claims received during the month and all split and replicate claims generated (recognized) during the month. (See the Medicare Claims Processing Manual for a discussion of what constitutes a claim.) Claims received include all claims received in its mailroom during the reporting month even though some of them were placed under computer control in the following month. (See §120.1 for counting receipts.)

The carrier counts claims submitted electronically after they have passed its consistency edits. Prior to that time, it may return these bills or the entire tape (where magnetic tape is the medium of submission), as necessary, without counting them as received. However, once the claims or tapes have passed consistency edits and are counted as received, it uses the actual receipt date, not the date the edits are passed, in calculating pending and processing times.

Line 5. Transferred to Other Carriers - The carrier reports the number of claims received, but transferred to other carriers or Part A intermediaries, during the month because the claimant submitted the claim to the wrong contractor. It includes claims transferred in their entirety or split off from other claims because they contained services from physicians/suppliers outside of their carrier jurisdiction.

Line 6. Net Number of Claims Received - The carrier shows the net number of claims (real and replicate) received after subtracting those transferred.

Line 7. Electronic Media Claims Received - The carrier reports the net number of claims included in line 6 which were received in paperless form via electronic media from providers or their billing agencies and read directly into its claims processing system. It does not count on this line claims that it received in hardcopy and entered using an Optical Character Recognition (OCR) device. It does not count any claims received in hardcopy and transformed into electronic media by any entity working for it directly or under subcontract.

It counts claims which are split automatically by computer, without manual intervention, as electronic media claims. This includes "required" splits only. (See the Medicare Claims Processing Manual. It excludes replicate claims).

Claims Processed

Line 8. Total CWF Claims - The carrier reports the number of initial claims (described in lines 9, 10 and 11 below) processed through Common Working File (CWF) and posted to CWF history. It does not include claims sent to CWF and rejected, unless they were resubmitted and posted to CWF history in the reporting month. The counts entered in lines 9, 10 and 11 are exclusive of each other and represent the total number of CWF claims (real or replicate) processed during the month. On page 1, it reports these claims in the month it move the claim to a processed location in its system after receipt of the host's response to pay, apply entirely toward the deductible or deny in full. For pages 2-9, it reports these claims as processed in the month during which the scheduled payment date falls, which may be in a subsequent reporting period.

Line 9. Claims Paid - The carrier reports the number of initial CWF claims (real or replicate) that it approved for payment and for which the CWF host responded by accepting its determination during the month. It reports only claims which are completely processed. If payment is made on part of a claim and the remainder of the claim requires no payment or is denied for any reason, it reports the claim as paid. It reports claims that have been fully adjudicated, with a response having been received from the CWF host, and that are being held only due to the payment floor.

Line 10. Claims Applied Towards Deductible - The carrier enters the number of CWF claims (real or replicate) for which no payment was made because the deductible had not been met. It includes claims for which all charges were applied toward the deductible, as well as those for which some charges were denied.

Line 11 Claims Denied - The carrier reports the number of CWF claims (real or replicate) for which all services were denied because, for example, the beneficiary was not eligible for Part B benefits, the filing limitation was exceeded, or services were not covered.

Line 12. Total Non-CWF Claims - The carrier reports the number of initial claims (real or replicate) processed outside CWF. Non-CWF claims are those either rejected by or not submitted to CWF which it finally adjudicates outside of CWF and are, therefore, not posted to its history in the reporting month. It reports these claims as non-CWF, even if it plans to submit an informational record in the future. Also, it reports these claims in the month in which it made the determination as to their final disposition.

Line 13. Claims Approved - Of those claims reported on line 12 as not processed through CWF, the carrier reports the number approved for payment or with all charges applied toward the deductible.

Line 14. Claims Denied - Of those claims reported on line 12, the carrier reports the number on which all services were denied.

Line 15. Total Claims Processed - The carrier reports the sum of lines 8 and 12.

Line 16. Replicate Claims Processed - The carrier reports the number of replicate claims included under Total Claims Processed, line 15, column (1). Replicate claims are those claims split off from original (real) claim. Replicate claims are generally created because of computer line item limitations, the carrier is making partial payments, or it is carving out individual specialty types of services. (See the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 70.2.).

Closing Pending

Line 17. Claims Pending at End of Month - The system calculates the number of bills pending at the end of the month by adding line 3 (adjusted opening pending) to line 6 (net receipts) and subtracting line 15 (total processed). It does not report as pending those bills that the carrier has moved to a processed location after being accepted by the host and are holding only due to the payment floor. It reports such bills as processed on line 17.

Distribution by Days Elapsed Since Receipt

Line 18. 1-15 Days - The carrier enters the number of claims, by type, included in line 17 which are 1-15 days old.

Line 19. 16-30 Days - The carrier enters the number of claims, by type, included in line 17 which are 16-30 days old.

Line 20. 31-60 Days - The carrier enters the number of claims, by type, included in line 17 which are 31-60 days old.

Line 21. 61-90 Days - The carrier enters the number of claims, by type, included in line 17 which are 61-90 days old.

Line 22. Over 90 Days - The carrier enters the number of claims, by type, included in line 17 which are over 90 days old.

Claim Investigations

Line 23. Number of Claims Investigated During Month - The carrier reports the number of claims (real and replicate) that required contact during the month by telephone, correspondence, or automatic inquiry with physician, beneficiary, supplier, or social security office, or other entities outside the carrier for missing, incorrect, or inconsistent information. It counts only the number of claims investigated, not the number of contacts made.

130.3 - Part B - Inquiries

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

The carrier reports the number of responses it processed as a result of inquiries from, or on behalf of, Medicare beneficiaries or providers during the reporting month. It reports only inquiries processed related to the Medicare program. It excludes inquiries addressing its private line of business. It bases the data on actual counts, not on estimates or samples.

The carrier counts inquiries as follows:

Beneficiary - It counts one inquiry per contact (telephone, written, walk-in), regardless of how many claims the beneficiary inquires about. For example, if a beneficiary writes it about the status of two claims, it counts the response as one beneficiary written inquiry. It counts responses to re-contacts made by that beneficiary as an additional inquiry. It counts any inquiry made by a beneficiary, or by anyone on behalf of the beneficiary, except a provider.

Provider - It counts one inquiry per contact. For example, if a provider calls or writes it regarding the status of 10 claims, it counts the response as one provider-written or phone inquiry. It counts any inquiry made by a provider, or anyone on behalf of the provider, except a beneficiary. It counts inquiries regardless of whether they relate to assigned or unassigned claims.

- It counts beneficiary and provider inquiries as follows:

- It counts Medicare inquiries directed to it for a response if they are requests for information from beneficiaries or providers (physicians/suppliers) or their representatives.

- It does not count, as inquiries, professional relations activities and contacts (i.e., its training programs for providers on new requirements).

- It counts voice inquiries captured electronically as telephone inquiries, and electronic mail inquiries as written inquiries. It does not count electronic inquiries if the provider can access the carrier system to determine claim status without its involvement.

- It does not count inquiries related specifically to the physician fee freeze or MSP. (This is to achieve comparability with the CMS-1524 budget form, where all costs related to the fee freeze and MSP are reported on separate lines.)

- It counts congressional inquiries in the appropriate category (i.e., as a beneficiary inquiry if made on behalf of a beneficiary, and as a provider inquiry if made on behalf of a provider).

- It counts inquiries made by the RO or the SSA DO in the appropriate category if the inquires are on behalf of a beneficiary or a provider and relate to a specific claim. It does not count the inquiries if they are of a general nature (i.e., ongoing liaison necessary during monitoring of day-to-day operations).

- It does not count Part A inquiries if it handles all Part A inquiries for an intermediary on a routine basis. In this case, it charges the related costs to the intermediary. It does not include the volume of work on the CMS-1565.

- It counts misdirected telephone inquiries (i.e., those that must be referred to another source for response) as processed telephone inquiries. It does not count misdirected written inquiries.

- It does not count requests for reviews or hearings as inquiries. (See The Medicare Claims Processing, Beneficiary Correspondence and Administrative Appeals, for definitions of reviews and hearings.) It reports reviews and hearings on the CMS-2590, not on the CMS-1565.

- It does not count reopenings and revisions. For example, if a claim is denied for lack of information after the appropriate suspense period, and the physician/supplier or beneficiary submits the missing information, it does not count any actions taken subsequently. (See the

Medicare Claims Processing Manual, Chapter 34, Reopening and Revision of Claim Determinations and Decisions, for definitions of reopenings and revisions.)

It reports the number of inquiries from beneficiaries (column 2) and providers (column 3) as follows:

Line 24. Total Number Processed During Month - It enters the total number of inquiries processed during the month. It does not report the number of inquiries received.

Line 25. Telephone - It reports the number of telephone inquiries processed during the month.

Line 26. Walk-in Contact - It reports the number of walk-in inquiries processed during the month.

Line 27. Written - It reports the number of written inquiries responded to during the month.

130.4 - Part C - Miscellaneous Claims Data

(Rev. 126; Issued: 07-13-07; Effective: 01-01-08; Implementation: 01-07-08)

Medicaid Crossover Claims - This part of the report represents data on the volume of Medicaid crossover claims.

Line 28 Number Transferred to State Agencies - The carrier enters the total number of Medicaid crossover claims transferred to State agencies or their fiscal agents in the reporting month.

Line 29 Number Transferred Electronically - The carrier enters the total number of Medicaid crossover claims reported in line 28 which were transferred in the reporting month to State agencies, or their fiscal agents, via electronic media.

Optical Character Recognition Claims

Line 30 Total Claims - The carrier enters the number of claims received in hardcopy and entered using an OCR device. It does not count these claims as EMC claims on line 7, page 1, or in column 6, pages 2-9.

Medicare Summary Notices (MSNs)

Line 31 Total MSNs Mailed - The carrier enters the number of MSNs mailed to beneficiaries during the reporting month.

140 - Completing Pages Two through Eleven of the Carrier Performance Report

(Rev. 6, 08-30-02)

B3-13305

140.1 - Heading

(Rev. 6, 08-30-02)

B3-13305.1

These pages are referenced as Form T (pages 2-9) and Form E (pages 10-11) in the CROWD system. It completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

150 - Part D(1) - Claims Processing Timeliness - All Claims

(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

Pages 2-9 of the CMS-1565 include data on its activity in processing all claims to completion during the reporting period. A claim is counted as processed to completion on the scheduled payment date, which is the date the check is mailed, deposited in the provider's account, or transferred electronically. For non-paid claims, the date of completion is the date the MSN or other notice of final action on the claim is mailed. Data shown must be based on reliable counts of all claims (real and replicate) processing activity. The carrier does not estimate claim counts. It reports only data relating to initial claims (real and replicate) actions. It does not report data on requests for, or dispositions of, reviews, hearings, or reopenings of initial claim actions.

"Clean" claims are defined as those that do not require investigation or development external to the carrier's operation on a prepayment basis. Claims which do not meet the definition of "clean" are "other" claims. Claims paid are those for which some payment was made (i.e., payment greater than zero). Claims not paid are those for which no payment was made (i.e., claim charges applied completely toward deductible or fully denied).

On pages 2-9, the carrier reports:

- In column 1, the total number of claims processed to completion;
- In column 2, the number of "clean" claims paid;
- In column 3, the number of "other" claims paid;
- In column 4, the number of "clean" claims not paid;
- In column 5, the number of "other" claims not paid; and
- In column 6, the number of "clean" or "other" claims processed to completion, which were received via electronic media from providers or their billing agencies and read directly into the carrier's claims processing system. The carrier does not count on this line claims that it received in hardcopy and entered using an OCR device. It does not count any claims received in hardcopy and transformed into electronic media by any entity working for it directly or under subcontract.

The data in lines 1 through 37 of pages 2 through 9 represent the number of claims processed in the number of days shown on that line, counting from the date of receipt. Line 38 represents the sum of lines 1 -37. The date of receipt is defined for hard-copy and magnetic tape claims as the date of receipt in the mailroom. For EMC billed via terminal or equivalent, it is the date the claim passes all front-end edits. For split claims, whether required or replicate, the date of receipt is the date of receipt of the original claim material, not the date of the split.

To calculate the processing time for a claim, the carrier subtracts the Julian receipt date from the processed to completion Julian date. When the processed to completion date falls in the year following the year of receipt, it adds 365 to the Julian date of completion (or 366 if the year of receipt is a leap year). If a claim is processed to completion on the same day it is received, the processing time is one day. This definition applies to all lines of the report, including line 39.

On line 39, the carrier reports the mean processing time (PT) to one decimal place for each column. To calculate the mean PT, it adds the processing times for the claims shown in line 38 of that column, and divides by the number in line 38. It does not use the categories on the report to calculate the mean PT. Because of the aggregation of claims in lines 34-37, it uses the processing times for individual claims, as explained below, to make this calculation.

Mean PT Calculation for All Claims - To determine the mean PT for all claims:

- Subtract the Julian date of receipt from the Julian date of payment or equivalent action for those not paid for each claim.
- Accumulate the result to cell counter for number of days for all claims.
- Divide this result by the total number of claims.
- Round to one decimal place.

EXAMPLE:

Claim	**Julian Date Receipt**	**Paid**	**Counter by Days**	**Counter by Claims**
A	87103	87133	30	1
B	87105	87206	101	2
C	87115	87177	62	3
D	87120	87213	93	4
E	87122	87215	93	5
F	87130	87223	93	6

Total Days = 30 + 101 + 62 + 93 + 93 + 93 = 472
Mean = 472/6 = 78.6666 = 78.7
The carrier completes the report for each of the following claim types:

Page 2. **Assigned Physician** - It shows the number of **assigned** claims included on page 9 which involved services billed by physicians. Physicians are identified by specialty codes *01-14, 16-30, 33-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98 or 99*.

Page 3. **Assigned DME** - It shows the number of assigned claims included on page 9 which involved services billed by DME suppliers. DME suppliers are identified by specialty codes *51 - 58, 87, 88, 96, A0-A8, or B2-B5*.

Page 4. **Assigned Lab** - It shows the number of assigned claims included on page 9 which involved services billed by an independent laboratory. Independent laboratories are identified by specialty code 69.

Page 5. **Assigned Ambulance** - It shows the number of assigned claims included on page 9 which involved services billed by ambulance service suppliers. Ambulance service suppliers are identified by specialty code 59.

Page 6. **Assigned Other** - It shows the number of assigned non-physician claims included on page 9 but not represented on pages 3, 4, or 5.

Page 7. **Unassigned** - It shows the number of unassigned claims (real and replicate) included on page 9.

Page 8. **Participating Physician** - It shows the number of claims included on page 9 involving services rendered by physicians enrolled in the Medicare Physician/Supplier Participation Program.

Page 9. **All Claims** - It shows the total number of claims (real and replicate) processed during the month.

160 - Part D(2) - Claims Processing Timeliness - EMC Claims and Adjustments for CPEP CPT Calculations

(Rev. 6, 08-30-02)
B3-13307

Pages 10-11 of the CMS-1565 include data bills paid or denied during the month that were received via electronic media. The basic instructions and definitions that apply to pages 2-9 (see §150) also apply to pages 10-11. The carrier reports the following information for Participating Physician EMC claims (page 10) and all EMC claims (page 11):

- Column 1 - the number of EMC claims that were included in column 2 (paid clean) for the corresponding claim type on page 8 or 9, as appropriate.

- Column 2 - the number of EMC claims that were included in column 3 (paid other) for the corresponding claim type on page 8 or 9, as appropriate.

- Column 3 - the number of EMC claims that were included in column 4 (not paid clean) for the corresponding claim type on page 8 or 9, as appropriate.

For each claim type (PAR and TOT), the carrier reports the following adjustments for CPEP CPT calculations:

CWF - Claims which were beyond carrier control due to CWF.

A. The number of EMC clean claims processed beyond the EMC ceiling.
B. The number of paper clean claims processed beyond the paper ceiling.
C. The number of all claims processed beyond 60 days.

WAIVER - Claims paid under the floor for which the carrier had a waiver from CMS.

D. The number of EMC clean claims paid under the EMC floor.
E. The number of paper clean claims paid under the paper floor.
F. The number of all EMC claims paid under the EMC floor plus the number of all paper claims paid under the paper floor.

170 - Completing Page 12 of the Carrier Performance Report

(Rev. 6, 08-30-02)
B3-13308

170.1 - Classification of Claims for Counting

(Rev. 6, 08-30-02)

B3-13308.1

Claims data entered on page 12 of the performance report represent counts of claims (real and replicate) as defined in Ref.

170.2 - Heading

(Rev. 6, 08-30-02)
B3-13308.2

This page is referenced as Form V in the CROWD system.

The carrier completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

170.3 - Part E - Interest Payment Data

(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

The carrier reports on Page 12 of the CMS-1565 data on the claims on which it paid interest because it paid the claims after the required payment date per §9311 of the Omnibus Reconciliation Act of 1986 (OBRA 1986). It bases data shown on reliable counts of all claims processing activity, not on estimates. It reports data on initial claims only. It includes in the report all claims requiring interest payments in the month. It reports claims in the month the date of payment falls. (For a discussion of interest payments refer to the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Sections 80.2.2 and 80.2.2.1).

The carrier completes the report for each column as follows:

Column 1. Total - Data for all claims (real and replicate) for which interest payments were made during the month.

Column 2. Assigned Physician - Data for the **assigned** claims included in column 1 which involved services billed by physicians. Physicians are identified by specialty codes *01-14, 16-30, 33-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98 or 99*.

Column 3. Assigned DME - Data for the assigned claims included in column 1 that involved services billed by DME suppliers. DME suppliers are identified by specialty codes *51-58, 87, 88, 96, A0-A8, or B2-B5*.

Column 4. Assigned Lab - Data for the assigned claims included in column 1 that involved services billed by an independent laboratory. Independent laboratories are identified by specialty code 69.

Column 5. Assigned Ambulance - Data for the assigned claims included in column 1 that involved services billed by ambulance service suppliers. Ambulance service suppliers are identified by specialty code 59.

Column 6. Assigned Other - Data for the assigned non-physician claims included in column 1 but not represented in columns 3, 4, or 5.

Column 7. Unassigned - Data for the unassigned claims included in column 1.

Column 8. Participating Physician - Data for claims involving services rendered by physicians enrolled in the Medicare Physician/Supplier Participation Program.

On line 1, the carrier shows the number of claims on which it paid interest in the reporting month. It reports on line 2 the number of claims included in line 1 for which it made payment one day after the required payment date (e.g., the required payment date is 17 days after receipt for participating physician claims received in FY 1992.) (See §9311 of OBRA 1986.) Data for lines 3-10 are similar to those for line 2.

The carrier calculates the number of days late by subtracting the Julian date of the required payment date from the Julian date of payment.

On line 11, it shows the amount paid in interest for claims reported in line 1. On lines 12-20, it shows the amount paid in interest for claims reported in lines 2-10, respectively. It shows dollar amounts on lines 11-20 to the nearest penny, and includes the decimal point.

180 - Completing Page Thirteen of the Carrier Performance Report(Inactive)
(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

180.1 - Instructions for Completing the Carrier Performance Report - All Trunks Busy (ATB)
(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Each month the carrier prepares and submits to CMS Central Office (CO) page 13 of the Carrier Performance Report - ATB. This report contains the monthly data for ATB, for both local and toll free calls, the number of beneficiary calls answered in 120 seconds, and the total number of beneficiary calls received.

It reports these statistics electronically by the 15th of the month following the reporting month using the Medicare Contractor Reporting of Operational and Workload Data (CROWD) System at the CMS Data Center (CDC). It enters data on the ATB report screen for each office that has been assigned a separate carrier number.

180.2 - Heading
(Rev. 6, 08-30-02)
B3-13309.2

This page is referenced as Form R in the CROWD system.

The carrier completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

180.3 - Part F-ATB Data
(Rev. 6, 08-30-02)
B3-13309.3

The carrier completes the report for each line as follows:

Line 1, column 1 - percent, rounded to the nearest tenth, of all trunks busy (ATB) for local calls.

Line 1, column 2 - percent, rounded to the nearest tenth, of all trunks busy (ATB) for toll free calls.

Line 2, column 1 - number of local beneficiary calls answered in 120 seconds.

Line 2, column 2 - number of toll free beneficiary calls answered in 120 seconds.

Line 3, column 1 - number of local beneficiary calls received.

Line 3, column 2 - number of toll free beneficiary calls received.

Line 4, column 1 - percent, rounded to the nearest tenth, of local beneficiary calls answered in 120 seconds.

Line 4, column 2 -, rounded to the nearest tenth, of toll free beneficiary calls answered in 120 seconds.

EXPLANATION OF FAILURES: When the carrier fails the ATB level percentage standard or the timeliness standard for responding to telephone inquiries, it enters an explanation in this section. It makes the narrative as brief as possible. Refer to MCM-2, §5261.7 regarding the standards.

190 - Checking Reports Prior to Submittal to CMS

(Rev. 6, 08-30-02)
B3-13310

Prior to transmitting performance reports to CMS the carrier checks for the following:

- Completeness;
- Accuracy; and
- Internal consistency.

It uses the following checklists to assure accuracy and consistency:

A. Page One of Report (CROWD Form B)

- Line 1 of current report must be equal to line 17 of previous report for all columns; Line 1 + Line 2 = Line 3 for all columns;
- Line 4 - Line 5 = Line 6 for all columns;
- Line 7 should be equal to or less than Line 6 for all columns;
- Line 9 + Line 10 + Line 11 = Line 8 for all columns;
- Line 13 + Line 14 = Line 12 for all columns;
- Line 8 + Line 12 = Line 15 for all columns;
- Line 3 + Line 6 - Line 15 = Line 17 for all columns;
- For each line of this page (except for lines 16, 28, 29 and 30), column 1 must equal the sum of columns 2 and 3;
- Line 16 should be equal to or less than Line 15 for column 1;
- Lines 18 + 19 + 20 + 21 + 22 = Line 17 for all columns;
- Lines 25 + 26 + 27 = Line 24 for all columns; and

- Line 29 should be equal to or less than line 28.

B. Pages Two through Eleven (CROWD Forms T and E)

- For each of lines 1-38 on pages 2-9, column 1 = column 2 + 3 + 4 + 5;
- For each of lines 1-38 on pages 2-9, column 6 must be equal to or less than column 1;
- The sum of lines 1-37 must be equal to line 38 for all columns;
- Each data item on page 9, lines 1-38 = the sum of the corresponding data items on pages 2-7;
- Each data item on page 8, lines 1-38, must be equal to or less than the corresponding data item on page 2;
- For each of lines 1-38 on pages 10 and 11, column 1 must be less than or equal to column 2 on pages 8 and 9, respectively;
- For each of lines 1-38 on pages 10 and 11, column 2 must be less than or equal to column 3 on pages 8 and 9, respectively; and
- For each of lines 1-38 on pages 10 and 11, column 3 must be less than or equal to column 4 on pages 8 and 9, respectively.

C. Page Twelve (CROWD Form V) -

- For each line, column 1 = the sum of columns 2 - 7;
- For each column, line 1 = the sum of lines 2 - 10;
- For each column, line 11 = the sum of lines 12 - 20; and
- For each line, column 8 must be equal to or less than column 2.

D. Page Thirteen (CROWD Form R)

(Line 2 divided by line 3) times 100 = line 4 for all columns.

200 - Exhibits

(Rev. 126; Issued: 07-13-07; Effective: 01-01-08; Implementation: 01-07-08)

Exhibit 1 - Medicare Program Carrier Performance Report- Page 1

MEDICARE PROGRAM CARRIER PERFORMANCE REPORT- Page 1			
Carrier	Number	Report Period (Month/Yr)	Working Days
	Number and Type of Claim		
Reporting Item	Total (1)	Assigned (2)	Unassigned (3)
A. Monthly Workload Operations			
OPENING PENDING			
1. Claims Pndg End of Last Mo.			
2. Adjustments (Show + or -)			
3. Adjusted Opening Pending			

RECEIPTS			
4. Tot. Clms. Rcvd. During Mo.			
5. Transferred to Other Carrier			
6. Net Number of Claims Received			
7. Electronic Media Claims Recvd.			
CLAIMS PROCESSED			
8. Total CWF Claims			
9. Claims Paid			
10. Claims Applied To Deductible			
11. Claims Denied			
12. Total Non-CWF Claims			
13. Claims Approved			
14. Claims Denied			
15. Total Claims Processed			
16. Replicate Claims Processed			

Exhibit 1 (Cont.)

MEDICARE PROGRAM CARRIER PERFORMANCE REPORT- Page 1 (cont)			
Carrier	Number	Report Period (Month/Yr)	Working Days
	Number and Type of Claim		
Reporting Item	Total **(1)**	Assigned **(2)**	Unassigned **(3)**
CLOSING PENDING			
17. Claims Pending at End of Month			
DISTRIBUTION OF DAYS ELAPSED SINCE RECEIPT			
18. 1 - 15 Days			
19. 16 - 30 Days			
20. 31 - 60 Days			

21. 61 - 90 Days			
22. Over 90 Days			
CLAIMS INVESTIGATIONS			
23. No. of Clms. Invest. During Mo.			
B. INQUIRIES	TOTAL	BENEFICIARY	PROVIDER
24. Tot. No. Processed During Mo.			
25. Telephone			
26. Walk-In Contact			
27. Written			
C. MISCELLANEOUS CLAIMS DATA			
MEDICAID CROSSOVER CLAIMS			
28. No. Transferred to St. Agencies			
29. No. Transferred Electronically			

Exhibit 1 (Cont.)

MEDICARE PROGRAM CARRIER PERFORMANCE REPORT- Page 1 (cont)			
Carrier	Number	Report Period (Month/Yr)	Working Days
	Number and Type of Claim		
Reporting Item	Total (1)	Assigned (2)	Unassigned (3)
OPTICAL CHARACTER RECOGNITION CLMS.			
30. Total Claims			

MEDICARE SUMMARY NOTICES			
31. Total MSNs Mailed			

Form CMS-1565

Exhibit 2 - Medicare Program Carrier Performance Report - Form CMS-1565, Pages 2-9

MEDICARE PROGRAM CARRIER PERFORMANCE REPORT -
FORM CMS-1565, Pages 2-9

CARRIER WORKLOAD REPORT - PAGE __*__

PART - D (1) CLAIMS PROCESSING TIMELINESS - ALL CLAIMS

CARRIER ID________ TYPE OF CLAIM______*_____ REPORT MO.___

		PAID		NOT PAID		
LINE NO./DAYS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	EMC (6)
1 1						
2 2						
3 3						
4 4						
5 5						
6 6						
7 7						
8 8						
9 9						
10 10						
11 11						
12 12						
13 13						
14 14						
15 15						
16 16						
17 17						
18 18						

19 19						
20 20						
21 21						
22 22						
23 23						
24 24						
25 25						
26 26						
27 27						
28 28						
29 29						

Exhibit 2 (Cont.)

		PAID		NOT PAID		
LINE NO./DAYS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	EMC (6)
30 30						
31 31						
32 32						
33 33						
34 34-45						
35 46-60						
36 61-90						
37 91+						
38 Tot 1-37						
39 Mean Pt						

CMS-1565 Page _*_

* PAGE NUMBER AND TYPE OF CLAIM ARE TO BE REPORTED AS FOLLOWS:

Page 2-Assigned Physician
Page 3-Assigned DME
Page 4-Assigned Lab
Page 5-Assigned Ambulance
Page 6-Assigned Other
Page 7-Unassigned
Page 8-Participating Physician
Page 9-All Claim

Exhibit 3 - Adjustments for CPEP CPT

			EMC PAID		EMC NOT PAID	
ADJUSTMENTS FOR CPEP CPT						
LINE NO./DAYS			CLEAN (1)	OTHER (2)	CLEAN (3)	CALCULATIONS:
1		1				CWF Claims which were beyond carrier control due to CWF.
2		2				
3		3				
4		4				
5		5				A. EMC clean claims Processed beyond EMC
6		6				
7		7				
8		8				B. Paper clean claims Processed beyond Paper ceiling
9		9				
10		10				
11		11				C. All claims processed Beyond 60 days ____
12		12				
13		13				**WAIVER** Claims paid under the floor For which the carrier had a waiver from CMS.
14		14				
15		15				
16		16				
17		17				D. EMC clean claims Paid under EMC floor __________
18		18				
19		19				
20		20				E. Paper clean claims Paid under paper floor _________
21		21				
22		22				
23		23				F. All EMC claims paid under EMC floor and all paper claims paid under paper floor ___________
24		24				
25		25				
26		26				
27		27				
28		28				
29		29				
30		30				
31		31				
32		32				
33		33				

Exhibit 3 (Cont.)

LINE NO./DAYS			EMC PAID CLEAN (1)	EMC PAID OTHER (2)	EMC NOT PAID CLEAN (3)	CALCULATIONS:
34		34-45				
35		46-60				
36		61-90				
37		91+				
38		Tot 1-37				
39		Mean Pt				

CMS-1565 Page _*_

* PAGE NUMBER AND TYPE OF CLAIM ARE TO BE REPORTED AS FOLLOWS:
Page 10-Participating Physician (PAR)
Page 11-Total (TOT)

Exhibit 4 - Carrier Workload Report - Part-E - Interest Payment Data
CARRIER WORKLOAD REPORT - PAGE __*__
PART-E - INTEREST PAYMENT DATA

CARRIER ID
REPORT MONTH

LINE NO CLAIM/PAYMENT LATE DAYS	TOTAL (1)	ASTD PHYS (2)	ASTD DME (3)	ASTD LAB (4)	ASTD AMB (5)	ASTD OTHER (6)	UNASTD (7)	PARTIC. PHYS (8)
1. No. of Claims								
2. 1 Day late								
3. 2 Days Late								
4. 3 Days Late								
5. 4 Days Late								
6. 5 Days Late								
7. 6-15 A Late								
8. 16-30 A Late								
9. 31-60 A Late								
10. 61+ A Late								
11. Amount paid								
12. 1 Day late								
13. 2 Days Late								
14. 3 Days Late								
15. 4 Days Late								
16. 5 Days Late								
17. 6-15 A Late								
18. 16-30 A Late								
19. 31-60 A Late								
20. 61+ A Late								

Exhibit 5 - Carrier Workload Report - Part F - All Trunks Busy (ATB)

CARRIER WORKLOAD REPORT
PART F - ALL TRUNKS BUSY (ATB)

ALL TRUNKS BUSY
CARRIER ID____________ REPORT MONTH_________

	LOCAL CALLS (1)	TOLL FREE CALLS (2)
1. PERCENT OF ATB		
2. NUMBER OF BENEFICIARY CALLS ANSWERED IN 120 SECONDS		
3. TOTAL NUMBER OF BENEFICIARY CALLS RECEIVED		
4. % OF BENEFICIARY CALLS ANSWERED IN 120 SECONDS		
EXPLANATION FOR FAILURES:		

210 - Monthly DMEPOS State Report - General (Inactive)

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

If the carrier is a Durable Medical Equipment Regional Carrier (DMERC), it prepares and submits a report each month for its region (either A, B, C, or D - see §210.3 for exhibits) to CMS summarizing its performance in processing DMEPOS claims. It transmits the DMEPOS report as soon as possible after the end of the reporting month, but no later than the 10th day of the following month using the instructions contained in the CROWD User's Guide. It is also required to submit all pages of the CMS-1565 report for its total DMEPOS workload. It must also submit data on forms CMS-2174, CMS-2590, CMS-1564, CMS-1565A, and CMS-1565C via CROWD for its total DMEPOS workload.

210.1 - Completion of Items on the DMEPOS State Report

(Rev. 6, 08-30-02)

B3-13312.1

Heading - The carrier enters its assigned carrier number in the indicated space. In the space labeled, "Reporting Period", it enters the numerical month and year for which the report is prepared, e.g., it shows 1001 for the month October 2001. For each of the 8 pages of the report, the "Type" of claim is pre-entered by the CROWD system. Page 1 will be labeled "PEN" and be used to report PEN claims (HCPCS codes B0000-B9999; J0000-J9999). The remaining pages (2 thru 8) will be labeled and defined as follows:

PAGE	TYPE	HCPCS Codes
2	OXY (oxygen)	E0400-E0499; E1351-E1499
3	NOE (non-oxygen equipment)	E0000-E0399; E0500-E1350
4	DIA (dialysis supplies)	A4650-A4927; E1500-E1649
5	NDS (non-dialysis supplies)	A4200-A4640; A5051-A9999
6	PRO (prosthetics and orthotics)	L0000-L9999; V0000-V9999
7	OTH (other than the previous types above)	An example would be regional-wide code
8	TOT (total DMEPOS claims)	

If a claim contains more than one category type, the carrier reports the claim under each type identified. For example, it reports a claim including services for oxygen (OXY), non-oxygen equipment (NOE), and dialysis supplies (DIA) under page 2 (OXY), under page 3 (NOE), and under page 4 (DIA). As a result, this claim will end up being counted as 3 claims under page 8 (TOT).

For each of these types (pages 1 through 8), it enters data for lines and columns as follows:

Lines - data reflecting the total of all States and territories in its jurisdiction (region). On subsequent lines (2 and greater), enter data for each State and territory in its region.

Columns

Column 1, State Code - A code for the total of all States and an alpha code for each State and territory is pre-entered by the CROWD system.

Total Claims Processed for Type Indicated

Column 2, Number - total number of DMEPOS claims processed for type indicated during the month for all States and territories in its region.

The carrier reports claims in the month the payment date or other final adjudication occurs. See MCM-2, §5240, functional standard 11, for definition of payment date for all claims, including those fully denied or having charges applied completely towards the deductible. The total number of claims for all States (line 1) must be equal to or greater than the number reported on page 9, line 38, column 1 of the CMS-1565 that the carrier submits for the same month.

Column 3, In 1-60 Days - total number of DMEPOS claims in type indicated processed within 60 days during the month for all States and territories in its region. To calculate the processing time for a claim, the carrier subtracts the Julian receipt date from the processed to completion Julian date. The total number of claims processed for all States must be equal to or greater than the number reported on page 9, lines 1-35, of column 1 of the CMS-1565 submitted by the carrier for the same month.

Column 4, In 61-90 Days - total number of DMEPOS claims in type indicated processed in 61-90 days during the month for all States and territories in its region. The total number of claims processed for all States (line 1) must be equal to or greater than the number reported on page 9, line 36, column 1 of the CMS-1565 submitted by the carrier for the same month.

Column 5, Mean Processing Time - mean processing time for number of DMEPOS claims for type indicated processed during the month for all States and territories in its region. See §140.2 for an explanation on calculating the mean processing time. The carrier enters data to one decimal place.

Column 6, EMC - number of DMEPOS claims for type indicated processed to completion that were received via electronic media for all States and territories in its region. It does not include claims that the carrier receives in hardcopy and transfers to electronic media via character recognition devices. The total number of claims processed for all States (line 1) must be equal to or greater than the number reported on page 9, line 38, column 6 of the CMS-1565 that the carrier submits for the same month.

Clean Claims Processed for Type Indicated

Column 7, Number - total number of clean DMEPOS claims for type indicated processed during the month for all States and territories in its region. "Clean" claims are those that do not require an investigation or development **external** to the carrier operation on a prepayment basis. See MCM-2, §5240, functional standard 11, for definition of clean claims. The total number of "clean" claims processed for all States (line 1) must be equal to or greater than the number reported on page 9, line 38, column 2 + 4 of the CMS-1565, the carrier submits for the same month.

Column 8, In 1-30 Days - number of clean DMEPOS claims for type indicated processed 1-30 days for all States and territories in its region.

210.2 - Checking Report

(Rev. 6, 08-30-02)

B3-13312.2

Before transmitting the report to CMS CO, the carrier checks it for completeness and arithmetical accuracy. It uses the following checklist:

- Total All States, line 1, equals the sum of lines 2-20 for columns 2, 3, 4, 6, 7, and 8.
- For all lines, column 3 must be equal to or less than column 2.
- For all lines, column 4 must be equal to or less than column 2.
- For all lines, column 6 must be equal to or less than column 2.
- For all lines, column 7 must be equal to or less than column 2.
- For all lines, column 8 must be equal to or less than column 7.
- Line 1, column 2, page 8 must be greater than or equal to line 38, column 1, page 9 of the CMS-1565 submitted by the carrier for the same month.
- Line 1, column 3, page 8 must be greater than or equal to the sum of lines 1-35, column 1, page 9 of the CMS-1565 that the carrier submit for the same month.
- Line 1, column 4, page 8 must be greater than or equal to line 36, column 1, page 9 of the CMS-1565 that the carrier submit for the same month.
- Line 1, column 6, page 8 must be greater than or equal to line 38, column 6, page 9 of the CMS-1565 that the carrier submit for the same month.
- Line 1, column 7, page 8 must be greater than or equal to line 38, column 2 plus column 4, page 9 of the CMS-1565 that the carrier submit for the same month.

210.3 - Exhibits
B3-13312.3

Exhibit 1 - DMEPOS State Report - REGION A

DMEPOS State Report - REGION A

Carrier No.________ Report Period________ Type________

	Total Claims Processed for Type Indicated					Clean Claims Processed for Type Indicated	
State Code (1)	Number (2)	In 1-60 Days (3)	In 61-90 Days (4)	Mean Proc. Time (5)	EMC (6)	Number (7)	In 1-30 Days (8)
1-Tot. All States							
02 CT							
03 DE							
04 MA							
05 ME							
06 NH							
07 NJ							
08 NY							
09 PA							
10 RI							
11 VT							
12							
13							
14							
15							
16							
17							
18							
19							
20							

TYPE
Page 1-PEN
Page 2-Oxygen
Page 3-Non-Oxygen Equipment
Page 4-Dialysis Supplies
Page 5-Non-Dialysis Supplies

Page 6-Prosthetics and Orthotics
Page 7-Other
Page 8-Total

Exhibit 2 - DMEPOS State Report - REGION B

DMEPOS State Report - REGION B

Carrier No.________ Report Period________ Type________

	Total Claims Processed for Type Indicated					Clean Claims Processed for Type Indicated	
State Code (1)	Number (2)	In 1-60 Days (3)	In 61-90 Days (4)	Mean Proc. Time (5)	EMC (6)	Number (7)	In 1-30 Days (8)
1-Tot. All States							
02 DC							
03 IL							
04 IN							
05 MD							
06 MI							
07 MN							
08 OH							
09 VA							
10 WI							
11 WV							
12							
13							
14							
15							
16							
17							
18							
19							
20							

TYPE
Page 1-PEN
Page 2-Oxygen
Page 3-Non-Oxygen Equipment
Page 4-Dialysis Supplies
Page 5-Non-Dialysis Supplies
Page 6-Prosthetics and Orthotics
Page 7-Other
Page 8-Total

Exhibit 3 - DMEPOS State Report - REGION C

DMEPOS State Report - REGION C
Carrier No.________ Report Period________ Type________

	Total Claims Processed for Type Indicated					Clean Claims Processed for Type Indicated	
State Code (1)	Number (2)	In 1-60 Days (3)	In 61-90 Days (4)	Mean Proc. Time (5)	EMC (6)	Number (7)	In 1-30 Days (8)
1-Tot. All States							
02 AL							
03 AR							
04 CO							
05 FL							
06 GA							
07 KY							
08 LA							
09 MS							
10 NC							
11 NM							
12 OK2							
13 PR2							
14 SC2							
15 TN2							
16 TX2							
17 VI2							
18							
19							
20							

TYPE
Page 1-PEN
Page 2-Oxygen
Page 3-Non-Oxygen Equipment
Page 4-Dialysis Supplies
Page 5-Non-Dialysis Supplies
Page 6-Prosthetics and Orthotics
Page 7-Other
Page 8-Total

Exhibit 4 - **DMEPOS State Report - REGION D**

DMEPOS State Report - REGION D
Carrier No.________ Report Period________ Type________

	Total Claims Processed for Type Indicated					Clean Claims Processed for Type Indicated	
State Code (1)	Number (2)	In 1-60 Days (3)	In 61-90 Days (4)	Mean Proc. Time (5)	EMC (6)	Number (7)	In 1-30 Days (8)
1-Tot. All States							
02 AK							
03 AZ							
04 CA							
05 CM							
06 GU							
07 HI							
08 IA							
09 ID							
10 KS							
11 MO							
12 MT							
13 ND							
14 NE							
15 NV							
16 OR							
17 SD							
18 UT							
19 WA							
20 WY							

TYPE

220 - Quarterly Supplements to Carrier Performance Report (Forms CMS-1565A, CMS-1565B, CMS-1565C, CMS-1565D, and CMS-1565E) - General

(Rev. 6, 08-30-02)
B3-13320

In addition to the monthly workload report, the carrier prepares and transmits to CMS a Quarterly Supplement to the Carrier Performance Report showing the status and disposition of selected workloads. It prepares a separate report for each office/State that has been assigned a separate carrier number.

220.1 - Purpose and Scope

(Rev. 6, 08-30-02)
B3-13320.1

The Quarterly Supplements to the Carrier Performance Report (Forms CMS-1565A, CMS-1565B, CMS-1565C, CMS-1565D, and CMS-1565E) are the sources of current information on key aspects of carrier Medicare operations. The data, together with information from other sources, are used by CMS for:

- Identifying problem areas for resolution;

- Measuring trends in reasonable charge reductions, denial rates, and provider participation; Monitoring the workload handled by the carrier's Medicare Fraud and Abuse unit;

- Monitoring activity related to the carrier's Comprehensive Limiting Charge Compliance Program; and

- Monitoring activities dealing with the carrier's review of incentive payments made to physicians who render covered Medicare services in a rural or urban Health Professional Shortage Area (HPSA).

Carrier Instructions

220.2 - Due Date

(Rev. 6, 08-30-02)
B3-13320.2

The carrier transmits Forms CMS-1565A, CMS-1565B, CMS-1565C, and CMS-1565D to CO via PC or terminal as soon as possible after the end of the reporting quarter, but no later than the 15th of the following month, using instructions contained in Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide. With the exception of the due date, it applies these same instructions to Form CMS-1565E. The due date for the CMS-1565E is 75 days following the reporting quarter.

The carrier does not submit hardcopies of the reports.

230 - Completing Form CMS-1565A

(Rev. 6, 08-30-02)
B3-13321

230.1 - Classification of Claims for Counting

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Claims data entered on the performance report represent counts of claims (real and replicate). (See the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 70.8.2, for a definition of replicate claims). It includes in column (1) both assigned and unassigned claims. The carrier reports assigned claims in column (2) and unassigned claims in column (3).

240 - Completion of Items on Form CMS-1565A

(Rev. 6, 08-30-02)
B3-13322

240.1 - Heading

B3-13322.1

This report is referenced as Form A in the CROWD system. The carrier completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

240.2 - Part A - Claims Reduced and Denied

(Rev. 6, 08-30-02)
B3-13322.2

This part of the report provides CMS with:

- Current quarterly data on the results of carrier activity in determining reasonable charges;
- Information on the extent to which claims (real and replicate) are being denied or partially denied;
- The amount of charges disallowed as a result of carrier claims screening operations; and
- Information on the reasons items are denied and the savings realized.

The carrier reports only data relating to **initial** claims (real and replicate) actions in Part A of the report. It does not report data on disposition of informal reviews, hearings, or reopenings of an initial claim action in Part A. In order to be included in lines 1-7, the allowed amount on a service must be greater than $0. A claim must be reflected on more than one of lines 2-6 if appropriate. For example, if one service on a claim is reduced due to a fee schedule, and two services are reduced due to medical necessity, the carrier counts the claim once on line 2 and once on line 4. It reports the appropriate dollar amounts on lines 3 and 5.

Covered Charges

Line 1. Total Covered Charges for All Claims - total amount (rounded to the nearest dollar) of billed charges for covered services on all claims (real and replicate) paid or applied toward the deductible during the quarter. Claims paid or applied toward deductible are those reported in lines 9, 10, and 13 of the monthly CMS-1565 (CROWD Form B). For those claims in which reasonable charge/fee schedule reductions are made, the carrier reports the total covered charges prior to such reductions.

It does not include charges for otherwise covered services that are duplicates of previously submitted services, or should have been included in previously submitted services (e.g., global fee/rebundling situations).

Reasonable Charge/Fee Schedule Reductions

Line 2. Number of Claims With Reasonable Charge/Fee Schedule Reductions - number of claims (real and replicate) reported as paid (claims included under line 9 of the monthly Form B, applied toward the deductible (claims included under line 10 of the monthly Form B), or approved outside of Common Working File (CWF) (claims included under line 13 of the monthly Form B) in which the charges were reduced as a result of reasonable charge determinations or comparisons to fee schedules.

For provider-based physician claims, the **separation of charges** for physicians' services and charges for provider component (institutional) services according to some schedule of charges is **not a reasonable charge reduction.** The carrier counts a claim of this type as a reduced claim only if the submitted charge exceeds the provider billing agreement.

Line 3. Amount of Reduction (in dollars) - total amount (rounded to the nearest whole dollar) by which the claims (real and replicate) reported in line 2 were reduced as a result of reasonable charge determinations or fee schedules.

Medical Necessity Reductions

Line 4. Number of Claims with Medical Necessity Reductions - number of claims (real or replicate) where the carrier reduced the billed charges because of a determination that the level of service was not medically necessary (i.e., a lower level of service would have sufficed). It includes cases where the service was reduced because medical review determined that a lesser service was actually performed.

Line 5. Amount of Reduction (in dollars) - the difference (rounded to the nearest dollar) between the billed and allowed charges for those covered services included on line 4.

Global Fee/Rebundling Reductions

Line 6. Number of Claims with Global Fee/Rebundling Reductions - the number of claims (real or replicate) where the charges were reduced because one or more of the services in a global fee was previously paid. It does not include claims with services denied because they should have been included in a previously submitted global fee. The carrier reports such claims in line 17. (See MCM-3, §4630.)

Line 7. Amount of Reduction (in dollars) - the difference (rounded to the nearest dollar) between the billed and allowed charges for those covered services included on line 6.

Denials

In this section, the carrier reports data for claims (real and replicate) totally or partially denied. Claims totally denied are claims where it determines the allowed amount to be $0 for all services billed. Claims partially denied are claims where it determines the allowed amount to be $0 for some, but not all services.

The carrier does not report transfers of claims to other carriers or Part A intermediaries since these are not denials. It does not include claims returned to physicians or suppliers because they were lacking necessary information. (Returns are cases where no attempt was made to develop the claim.)

It does not report reductions in billed charges where the fee is deemed to have been included in a global fee, such as postsurgical care. It includes such services only if the allowed amount is $0 (i.e., the service is denied). It reports data for such services reduced to an amount greater than $0 on lines 6 and 7 above.

Line 8. Claims Denied in Full or in Part - the sum of (l) those claims (real and replicate) reported as denied in full on lines 11 and 14 of the Form B submitted for the three months of the reporting calendar quarter, plus (2) those claims (real and replicate) reported as paid or applied toward the deductible in which some charges, but not all, were denied. Claims paid or applied toward deductible are those reported on lines 9, 10 and 13 of the monthly Form B.

Line 9. Amount Disallowed (in dollars) - the total amount (rounded to the nearest dollar) of charges disallowed (billed charges for denied services) on the claims (real and replicate) reported on line 8.

Reason for Denial - On lines 10-18 the carrier enters the number of items denied (column 1), the amount (rounded to the nearest dollar) disallowed (column 2), and the number of claims disallowed (column 3).

The items reported in column 1 of this section represent the number of separate items coded by the carrier which were denied. These items usually relate to a single service, but may also represent more than one service when multiple occasions of the same type of service are coded as a single item. Line 19 for column 1 should contain the total number of items denied. Since more than one item on a claim may be denied, the total on line 19 for items denied (column 1) will usually be larger than the total number of claims denied in full or in part shown on line 8, column 1. However, the total money shown in column 2 on line 19 for amount disallowed must equal the total amount disallowed shown on line 9, column 1.

The carrier shows a claim that contains multiple services, but is denied for only one reason, only once in column 3 under that reason for denial. However, if a claim is denied for more than one reason, it shows it under each reason for denial. Therefore, line 19, for the total number of claims disallowed (column 3), will usually be larger than the number of claims denied in part or full on line 8 (column 1).

Line 10. Claimant Ineligible - the number of items denied, the related amount (in rounded dollars) of total charges disallowed, and the number of claims denied because the recipient of services was ineligible for Part B benefits, or because the services billed were rendered before the beneficiary's coverage for Part B benefits began, or after coverage was terminated.

Line 11. Filing Limitation Exceeded - the number of items denied, the related amounts (in rounded dollars) of total charges disallowed, and the number of claims denied because the claim was filed later than the time limitation on filing claims. (See MCM-3, §3004.)

Line 12. Duplicate Claim - the number of items denied, the related amount (in rounded dollars) of total charges disallowed, and the number of claims denied because the services billed duplicated those from previously filed claims. The only denials reported on line 12 are actual duplicate charges for the same item or service. The carrier does not report denials for duplicate medical equipment (see line 14) or charges for services which are deemed to be included in a global fee (see line 17).

Line 13. Services Not Covered - the number of items denied, the related amount (in rounded dollars) of charges disallowed and the number of claims denied because the services billed are determined to be excluded from coverage under the SMI program for reasons other than a finding that the services were not medically necessary. Some examples of services not covered are:

- Services with charges above 62.5 percent of psychiatric charges;
- Services with charges over $1,375 annual psychiatric expenses;
- Services with charges over $100.00 annual therapist expenses;
- First three pints of blood;
- Equipment or services not ordered or prescribed by a physician;
- Manipulation of spine when no X-ray is submitted;
- Services by noncertified labs, nonapproved ambulance services or supplies;
- Nonambulance transportation;
- Services provided by relative/household member;
- Services provided where there is no legal obligation to pay;
- Routine physical check up, immunization shots, prescription drugs, personal comfort items, eyeglasses, hearing aids, etc.;
- Care outside United States;
- Rental or purchase of DME for inpatients of hospitals or SNFs;

- Service date is before provider's participation effective date or after provider's termination date;

- Services, supplies, or rental of equipment not needed during a period when the beneficiary was hospitalized; or

- Ambulance beyond nearest appropriate facility.

Line 14. Services Not Medically Necessary - the number of items denied, the related amount (in rounded dollars) of charges disallowed and the number of claims denied because it was determined that the services billed were not medically necessary. Some examples are:

- Ambulance not medically necessary, e.g., transfers between similar hospitals for reasons other than medical necessity;

- Care for same illness by another attending physician;

- Medical equipment which is not needed for the patient's condition or which continues to be used after medical necessity has ceased;

- Duplicate medical equipment;

- Services not substantiated as necessary by medical review;

- Vitamins or other injections not considered necessary for patient's diagnosis;

- More than one nursing home visit per month by physician unless medical need is documented; and

- Manipulation of spine when subluxation is not verified by X-ray.

Line 15. MSP - the number of items denied, the amount (in rounded dollars) of charges disallowed, and the number of claims denied because it was determined that Medicare should have been secondary to another payer. (See MCM-3, §§3330-3340.)

Line 16. Missing Information - the number of items denied, the amount (in rounded dollars) of charges disallowed, and the number of claims denied because the claimant failed to provide information necessary to process the claim.

Line 17. Global Fee/Rebundling - the number of items denied, the amount (in rounded dollars) of charges disallowed, and the number of claims denied because the fee was deemed to have been included in a previously allowed global fee, or a charge for a rebundled set of codes.

Line 18. Other - the number of items denied, the related amount (in rounded dollars) of charges disallowed, and the number of claims denied for reasons other than those specified on lines 10-16. Some examples of items to be reported here are:

- Services or rental is billed in advance; and

- Representative payee's form not on file.

Line 19. Total - the total number of items denied, the related amount (in rounded dollars) disallowed and the number of denied claims reported on lines 10-18.

240.3 - Checking Form A Prior to Submittal to CMS

(Rev. 6, 08-30-02)
B3-13322.3

Prior to submitting Form A to CMS, the carrier checks for completeness, accuracy, and internal consistency.

It uses the following checklist to assure accuracy and consistency:

- For lines 1 through 9 and 20 and 21, column 1 must equal the sum of columns 2 and 3;

- Each of lines 2, 4, and 6 must be less than or equal to the total sum of lines 9, 10 and 13 on the Form B submitted for the three months in the quarter;

- The sum of lines 3, 5, and 7 must be less than or equal to line 1 for each column;

- Line 8 should be at least equal to, but in most cases greater than, the accumulated total for lines 11 and 14 on the Form B submitted for the three months in the quarter;

- Lines 10 + 11 + 12 + 13 + 14 + 15 + 16 + 17 + 18 = line 19 for all columns;

- The total number of items denied as reported on line 19, column 1 should be at least equal to, but in most cases greater than, the total number of claims denied in full or in part as reported on line 8 column 1;

- The dollar amount disallowed reported in the first column of line 9 and the second column of line 19 must be equal; and

- The total number of claims denied reported on line 19, column 3 must be at least equal to, but in most cases greater than the total number of claims denied in full or in part as reported on line 8, column 1.

250 - Completing Medicare Fraud Unit Quarterly Workload Status Report, CMS-1565B - General

(Rev. 6, 08-30-02)
B3-13323

The carrier prepares and submits to CMS each quarter a report on the number of fraud workload items handled by its Medicare fraud unit. This information is required by CMS to budget for fraud and abuse activities, as well as to monitor the flow of work through the fraud units. It submits this form via the CROWD system no later than the fifteenth day following the close of the reporting quarter.

250.1 - Heading
(Rev. 6, 08-30-02)
B3-13323.1

This report is referenced as Form M in the CROWD system. The carrier completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

250.2 - Checking Reports
(Rev. 6, 08-30-02)
B3-13323.2

Before submitting Form M to CMS, the carrier checks for completeness and arithmetical accuracy. It uses the following checklist:

- For all columns, line 1 must equal line 8 of Form M for the previous quarter.
- For all columns, line 1 + line 2 = line 3.
- For all columns, line 6 + line 7 = line 5.
- For all columns, line 3 + line 4 - line 5 = line 8.
- For all lines, column 1 = column 2 + column 3 + column 4.

250.3 - Type of Fraud Workload Item
(Rev. 6, 08-30-02)
B3-13323.3

The carrier reports fraud workload items in the following columns for all lines of Form M:

Column (1) - Total - All fraud workload items.

Column (2) - Beneficiary Complaints - The number of complaints received from, or on behalf of, beneficiaries alleging fraud. The carrier does not include complaints filed with the Office of the Inspector General (OIG) Hotline.

Column (3) - OIG Hotline - The number of complaints received via the OIG Hotline.

Column (4) - Referrals and Other - Referrals and any other workload received by the fraud unit (e.g., provider complaints, internally generated referrals from medical review, special requests from OIG or CMS).

250.4 - Body of Report
(Rev. 6, 08-30-02)
B3-13323.4

Line 1. Opening Pending - The system will pre-fill the number pending from line 8 of the previous quarter's report.

Line 2. Adjustments - If it is necessary to revise the pending figure for the close of the previous quarter because of inventories, reporting errors, etc., the carrier enters the adjustment on this line. It precedes negative adjustments with a minus sign.

Line 3. Adjusted Pending - The system will sum line 1 + line 2 to calculate the adjusted opening pending.

Line 4. Workload Received - The number of complaints and referrals received in the fraud unit during the reporting period.

Line 5. Total Cleared - The system will sum line 6 + line 7 to calculate the total number of complaints and referrals cleared by the fraud unit during the reporting period.

Line 6. Cleared by Contractor - The number of complaints and referrals cleared by the fraud unit by means other than referral to the OIG or designated agency. The carrier includes those that were:

- Closed as not substantive or not a fraud issue.

- Closed as not a fraud issue, but referred to another contractor component for their review or action.

- Closed as not being a fraud issue, but referred to an external component other than the OIG.

Line 7. Cleared by Referral - The number of complaints and referrals that were incorporated into cases referred formally to the OIG or designated agency for action (e.g., sanctions or prosecution).

Line 8. Closing Pending - The system will calculate the closing pending for the quarter by adding line 3 to line 4, and subtracting line 5.

260 - Completing Form CMS-1565C

(Rev. 6, 08-30-02)
B3-13324

260.1 - Classification of Claims for Counting

(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

All claims data entered on the CMS-1565C must represent counts of claims (real and replicate) as defined in the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 70. The carrier classifies the claims on the report form as follows: (1) An assigned claim submitted by a non-participating physician or supplier; (2) An unassigned claim, usually submitted by a beneficiary and accompanied by bills from one or more physicians or suppliers; or (3) A claim submitted by a participating physician or supplier.

The terms "participating" and "non-participating" refer to whether or not the physician/supplier has signed an agreement to follow the provisions of the Medicare Physician/Supplier Participation Program. The carrier classifies claims as follows:

- A claim in which all services were provided when the physician/supplier was "participating" as a participant claim, and

- A claim with a mix of participant and non-participant services (including those cases where a physician/supplier has changed status) as a participant claim.

NOTES: An exception to the above is the unassigned claim involving services by a participating physician/supplier. If the carrier denies this type of claim, it classifies it as a non-participant, unassigned claim. When the corresponding claim is submitted by the beneficiary's physician (supplier), it classifies it as a participant claim.

The above classification rules apply only to claims. Services, covered charges, and disallowed charges should be allocated according to the participation status of the physician/supplier at the time the service was provided.

The carrier makes the distinction between physician and non-physician claims and services according to the coding used for the Bill Summary Record. It classifies those entities with specialty codes of *01-14, 16-30, 33-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98 or 99* as physicians. It considers all others to be non-physicians.

270 - Completion of Items on Form CMS-1565C

(Rev. 6, 08-30-02)
B3-13325

270.1 - Heading

(Rev. 6, 08-30-02)
B3-13325.1

This report is referenced as Form G in the CROWD system. The carrier completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen. It must submit Form A for the reporting quarter before the system will allow it to submit Form G for the same quarter.

270.2 - Part D - Selected Claim Data by Participation Status

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

This part provides CMS with current quarterly workload data on the results of carrier activity in processing claims for physician and non-physician services according to the participation status of the physician/supplier. It also provides important related information on reasonable charge determinations, the extent to which claims for such services are being denied, and the amount of charges disallowed.

The carrier reports only data relating to **initial** claims (real and replicate) actions. It does not report data on the disposition of reviews, hearings, or reopenings of initial claim actions.

It reports data for lines 1-34 for each column (participation/assignment status) as defined in the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 30. unless otherwise stated. Specialty codes for physicians and non-physicians are listed in the Medicare Claims Processing Manual, Chapter 26, Sections 10.8.2 and 10.8.3.

Line 1. Number of Claims Approved - total number of claims, processed to completion during the quarter, which were paid or applied to the deductible. Claims paid or applied toward the deductible are those reported in lines 9, 10, and 13 of Form B. The system will pre-fill columns 1 and 3 based on the total of these lines from the monthly reports.

Line 2. Physician Only - number of claims included in line 1 involving physician services only.

Line 3. Physician and Non-Physician - number of claims included in line 1 involving both physician and non-physician services on the same claim. The carrier shows all claims in this category under the "Non-Participant-Unassigned" column 3. Therefore, the numbers for columns 1 and 3 should be equal.

Line 4. Non-Physician Only - number of claims included in line 1 involving non-physician services only.

Line 5. Number of Covered Services - total number of **covered** services on the claims approved as shown on line 1. The carrier does not include services for which charges were completely disallowed.

Line 6. Physician - number of physician services included in line 5. The carrier includes in this count the covered services from the claims shown in line 2 plus the covered **physician** services from the claims shown in line 3.

Line 7. Non-Physician - number of non-physician services included in line 5. The carrier includes in this count the covered services from the claims shown in line 4 plus the covered **non-physician** services from the claims shown in line 3.

Line 8. Amount of Covered Charges - total amount (rounded to the nearest dollar) of billed charges for the covered services shown in line 5. For those services in which any charges were reduced as a result of reasonable charge, medical necessity, or global fee/rebundling determinations, the carrier reports the total covered charges prior to such reductions. The system will pre-fill columns 1 and 3 with the data reported in the respective columns on line 1 of Form A for the same quarter.

Line 9. Physician - total amount (rounded to the nearest dollar) of billed charges for the covered physician services shown in line 6. For those services in which any charges were reduced as a result of reasonable charge, medical necessity, or global fee/rebundling determinations, the carrier reports the total covered charges prior to such reductions.

Line 10. Non-Physician - total amount (rounded to the nearest dollar) of billed charges for the covered non-physician services shown in line 7. For those services in which any charges were reduced as a result of reasonable charge, medical necessity, or global fee/rebundling determinations, the carrier reports the total covered charges prior to such reductions.

Line 11. Number of Claims Where Billed Charges Were Reduced - number of claims (real and replicate) reported on line 1 as approved in which any charges were reduced as a result of reasonable charge/fee schedule, medical necessity, or global fee/rebundling determinations. The carrier counts a claim only once, regardless of the number of services reduced or the different categories of reductions that apply. Some examples of such reductions are:

a. Charges over allowed rental limits
b. Tests included in a battery of tests,
c. Fee covered in basic allowance or surgical allowance,
d. Service included in office charge or surgery fee.

Line 12. Physician Only - number of claims included in line 11 involving physician services only.

Line 13. Physician and Non-Physician - number of claims included in line 11 involving both physician and non-physician services on the same claim. The carrier shows all claims in this category under the "Non-Participant-Unassigned" column 3. Therefore, the numbers for columns 1 and 3 should be equal.

Line 14. Non-Physician Only - number of claims included in line 11 involving non-physician services only.

Line 15. Number of Covered Services Where Charges Were Reduced - From the claims shown in line 11, the carrier enters the number of covered services in which any charges were reduced as a result of reasonable charge determinations, medical necessity reductions, or global fee/rebundling reductions. It includes services where a fee is deemed to have been included in a global fee, such as postsurgical care. (See examples given for line 11.)

Line 16. Physician - number of covered physician services included in line 15. This count includes those services where charges were reduced on the claims shown in line 12, plus the **physician** services where charges were reduced on the claims shown in line 13.

Line 17. Non-Physician - number of covered non-physician services included in line 15. This count includes those services where charges were reduced on the claims shown in line 14, plus the **non-physician** services where charges were reduced on the claims shown in line 13.

Line 18. Total Amount of Reduction - total amount (rounded to the nearest dollar) by which the services reported in line 15 were **reduced** as a result of reasonable charge, medical necessity, or global fee/rebundling determinations. The system will pre-fill columns 1 and 3 with the sum of the data reported in the respective columns on lines 3, 5, and 7 of Form A for the same quarter.

Line 19. Physician - total amount (rounded to the nearest dollar) by which charges for physician services reported in line 16 were reduced as a result of reasonable charge, medical necessity, or global fee/rebundling determinations.

Line 20. Non-Physician - total amount (rounded to the nearest dollar) by which charges for non-physician services reported in line 17 were reduced as a result of reasonable charges, medical necessity, or global fee/rebundling determinations.

Line 21. Number of Claims Denied in Full - total number of claims, processed to completion during the quarter, in which charges for all services were completely disallowed. This number must equal the sum of the numbers reported in lines 11 and 14 of Form B for the three months of the quarter. The system will pre-fill columns 1 and 3 based on the total of these lines from the monthly reports.

Line 22. Physician Only - number of claims included in line 21 involving physician services only.

Line 23. Physician and Non-Physician - number of claims included in line 21 involving both physician and non-physician services on the same claim. The carrier shows all claims in this category under the "Non-Participant- Unassigned" column 3. Therefore, the numbers for columns 1 and 3 should be equal.

Line 24. Non-Physician Only - number of claims included in line 21 involving non-physician services only.

Line 25. Number of Claims Denied in Full or in Part - sum of (1) those claims (real and replicate) reported as denied in full in line 21, plus (2) those claims (real and replicate) reported as approved on line 1 in which some services, but not all, were denied. The system will pre-fill columns 1 and 3 with the data reported in the respective columns on line 8 of Form A for the same quarter.

Line 26. Physician Only - number of claims included in line 25 involving physician services only.

Line 27. Physician and Non-Physician - number of claims included in line 25 involving both physician and non-physician services on the same claim. The carrier shows all claims in this category under the "Non-Participant-Unassigned" column 3. Therefore, the numbers for columns 1 and 3 should be equal.

Line 28. Non-Physician Only - number of claims included in line 25 involving non-physician services only.

Line 29. Number of Denied Services - number of services for which charges were fully or partially denied on the claims shown in line 25.

Line 30. Physician - number of denied physician services included in line 29. The carrier includes in this count the denied services from the claims shown in line 26 plus the denied **physician** services from the claims shown in line 27.

Line 31. Non-Physician - number of denied non-physician services included in line 29. The carrier includes in this count the denied services from the claims shown in line 28, plus the denied **non-physician** services from the claims shown in line 27.

Line 32. Amount Disallowed - total amount (rounded to the nearest dollar) of charges disallowed on the services shown in line 29. The system will pre-fill columns 1 and 3 with the data reported in the respective columns on line 9 of Form A for the same quarter.

Line 33. Physician - total amount (rounded to the nearest dollar) included in line 32 as disallowed which represented physician services as reported in line 30.

Line 34. Non-Physician - total amount (rounded to the nearest dollar) included in line 32 as disallowed which represented non-physician services as reported in line 31.

270.3 - Checking Form G Prior to Submittal to CMS

(Rev. 6, 08-30-02)
B3-13325.3

Prior to submitting Form G to CMS, the carrier checks for completeness, accuracy and internal consistency. It uses the following checklist to assure accuracy and consistency:

1. For all lines, column 1 must equal the sum of columns 2 through 4,
2. Line 1 should equal the sum of lines 2 through 4 for all columns,
3. Line 5 should be greater than or equal to line 1 for all columns,
4. Line 5 should equal the sum of lines 6 and 7 for all columns,
5. Line 8 should be greater than or equal to line 5 for all columns,
6. Line 8 should equal the sum of lines 9 and 10 for all columns,
7. Line 9 should be greater than or equal to line 6 for all columns,
8. Line 10 should be greater than or equal to line 7 for all columns.
9. Line 11 should be less than or equal to line 1 for all columns,
10. Line 11 should equal the sum of lines 12-14 for all columns,
11. Line 12 should be less than or equal to line 2 for all columns,
12. Line 13 should be less than or equal to line 3 for all columns,
13. Line 14 should be less than or equal to line 4 for all columns,
14. Line 15 should be greater than or equal to line 11 for all columns,
15. Line 15 should equal the sum of lines 16 and 17 for all columns,
16. Line 15 should be less than or equal to line 5 for all columns,
17. Line 16 should be less than or equal to line 6 for all columns,
18. Line 17 should be less than or equal to line 7 for all columns,
19. Line 18 should be less than or equal to line 8 for all columns,
20. Line 18 should equal the sum of lines 19 and 20 for all columns,
21. Line 19 should be less than or equal to line 9 for all columns,
22. Line 20 should be less than or equal to line 10 for all columns,
23. Line 21 should equal the sum of lines 22-24 for all columns,
24. Line 25 should be greater than or equal to line 21 for all columns,
25. Line 25 should be equal to the sum of lines 26-28 for all columns,
26. Line 26 should be greater than or equal to line 22 for all columns,
27. Line 27 should be greater than or equal to line 23 for all columns,
28. Line 28 should be greater than or equal to line 24 for all columns,
29. Line 29 should be greater than or equal to line 25 for all columns,
30. Line 29 should equal the sum of lines 30 and 31 for all columns,
31. Line 32 should equal the sum of lines 33 and 34 for all columns;

32. Column 1 should equal column 3 for lines 3, 13, 23 and 27.
33. The following comparisons should be made between Form G and two other related forms, the CMS-1565 (Form B) and the CMS-1565A (Form A):

    a. Line 1, column 1, of Form G must equal the sum of lines 9, 10, + 13, column 1 of Form B for the reporting months.

    b. Line 1, sum of columns 2 + 4 of Form G must equal the sum of lines 9, 10, + 13, column 2 of Form B for the reporting months.

    c. Line 1, column 3 of Form G must equal sum of lines 9, 10, + 13, column 3 of Form B for the reporting months.

    d. Line 21, column 1 of Form G must equal sum of lines 11 + 14, column 1 of the CMS-1565 for the reporting months.

    e. Line 21 sum of columns 2 + 4 of Form G must equal sum of lines 11 + 14, column 2 of Form B for the reporting months.

    f. Line 21, column 3 of Form G must equal sum of lines 11 + 14, column 3 of the Form B for the reporting months.

    g. Line 8, column 1 of Form G must equal line 1 column 1 of Form A for the same quarter.

    h. Line 8, sum of columns 2 + 4 of Form G must equal line 1 column 2 of the Form A for the same quarter.

    i. Line 8, column 3 of Form G must equal line 1 column 3 of Form A for the same quarter.

    j Line 11, column 1 of Form G must be less than or equal to the sum of lines 2, 4 + 6, column 1 of Form A for the same quarter.

    k. Line 11, sum of columns 2 + 4 of Form G must be less than or equal to the sum of lines 2, 4 + 6, column 2 of the Form A for the same quarter.

    l Line 11, column 3 of Form G must be less than or equal to the sum of lines 2, 4 + 6 column 3 of Form A for the same quarter.

    m. Line 18, column 1 of Form G must equal sum of lines 3, 5 + 7, column 1 of Form A for the same quarter.

    n. Line 18, sum of columns 2 + 4 of Form G must equal sum of lines 3, 5 + 7, column 2 of Form A for the same quarter.

    o. Line 18, column 3 of Form G must equal sum of lines 3, 5 + 7, column 3 of Form A for the same quarter.

p. Line 25, column 1 of Form G must equal line 8 column 1 of Form A for the same quarter.

q. Line 25, sum of columns 2 + 4 of Form G must equal line 8 column 2 of Form A for the same quarter.

r. Line 25, column 3 of Form G must equal line 8, column 3 of Form A for the same quarter.

s. Line 32, column 1 of Form G must equal line 9, column 1 of Form A for the same quarter.

t. Line 32 sum of columns 2 + 4 of Form G must equal line 9 column 2 of Form A for the same quarter.

u. Line 32, column 3 of Form G must equal line 9, column 3 of Form A for the same quarter.

280 - Completing Comprehensive Limiting Charge Compliance Program (CLCCP) Quarterly Report, CMS-1565D - General

(Rev. 6, 08-30-02)
B3-13326

The carrier prepares and submits to CMS each quarter, a report on carrier CLCCP activity including such items as the number of Limiting Charge Exception Reports (LCERs), Limiting Charge Monitoring Reports (LCMRs), and Sanction Referral Letters (SRLs) sent during the quarter. It prepares its quarterly report based on the data captured in its cycle management reports in accordance with MCM, §7555.6ff.

280.1 - Heading

(Rev. 6, 08-30-02)
B3-13326.1

This report is referenced as Form N in the CROWD system. The carrier completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

280.2 - Checking Reports

(Rev. 6, 08-30-02)
B3-13326.2

Before submitting Form N to CMS, the carrier checks for completeness and arithmetical accuracy. It uses the following checklist:

- Line 5 must be greater than or equal line 4.
- Line 6 must be less than or equal line 5.
- Line 7 must be less than or equal line 5.

- Line 15 must be less than or equal line 14.

280.3 - LCER Data

(Rev. 6, 08-30-02)
B3-13326.3

The carrier reports in items 1-4 numbers of LCERs sent, not the number of providers receiving LCERs. Each of these items, therefore, will be the sum of the numbers shown on its cycle reports for the period.

Line 1 - LCERs Sent to Individual Physicians - The carrier reports the total number of LCERs sent to individual physicians during the period.

Line 2 - LCERs Sent to Group Practices - The carrier reports the total number of LCERs sent to group practices of physicians during the period.

Line 3 - LCERs Sent to All Other Providers - The carrier reports the total number of LCERs sent to all providers other than individual physicians, or group practices of physicians.

Line 4 - Total LCERs Sent for Period - The system will sum lines 1, 2, and 3 to calculate this field.

Line 5 - Total Claims on LCERs Sent - The carrier reports the total number of claims included on all of the LCERs sent for the period.

Line 6 - Claims Selected for Verification - The carrier reports the total number of claims selected for verification of refund/adjustment during the reporting period.

Line 7 - Beneficiaries with Claims on LCERs - The carrier reports the sum of the number of individual beneficiaries counted on its cycle reports for the period. Although an individual is to be counted only once on any particular cycle report, if the individual has claims on more than one cycle report, that individual will be counted more than once on the quarterly report.

280.4 - Monetary Data

(Rev. 6, 08-30-02)
B3-13326.4

The carrier reports all dollar amounts to two decimal places on lines 8-13. It reports the sum of the net figures for all of the cycles in the reporting period. It calculates and includes changes because of adjustments to claims in a cycle, or from a previous cycle, so that these figures accurately reflect the relationship between allowed dollars and excess dollars. Adjustments which leave overcharges of less than $1.00 may affect the total dollar value reported on line 13, thus it may not always equal the amount reported on line 9.

Line 8 - Total Dollars Allowed - The carrier reports the total dollars allowed from the sum of the cycle reports for the period.

Line 9 - Dollars in Excess of Limiting Charge - The carrier reports the total dollars in excess of the limiting charge from the sum of the cycle reports for the period.

Lines 10-13 - Procedures with Related Excess Charges - The carrier reports on lines 10-13 the total number of procedures (column 1), and related total dollar value of excess charges (column 2) that fall within each of the dollar ranges of excess charges on the respective lines: Line 10 is $1.00 - 4.99, line 11 is $5.00 -499.99, and line 12 is $500.00 + . The carrier need not complete line 11, as the system will calculate it by subtracting lines 10 and 12 from line 13 (Total).

280.5 - Verification Data for Refunds and Adjustments

(Rev. 6, 08-30-02)
B3-13326.5

Line 14 - Verifications Posted to the Limiting Charge Exception File (LCEF) - The carrier reports the total number of acceptable verifications posted to the LCEF.

Line 15 - Not Requested on LCER - The carrier reports the number of acceptable verifications included on line 14 that were not requested on an LCER.

Line 16 - Unacceptable Verifications - The carrier reports the number of verifications received, either because of an LCER or unsolicited, that were unacceptable, (i.e., posted as unacceptable to the LCEF or could not be associated with an LCEF record).

280.6 - LCMR Data

(Rev. 6, 08-30-02)
B3-13326.6

Line 17 - LCMRs Sent to Individual Physicians - The carrier reports the total number of LCMRs sent to individual physicians during the reporting period.

Line 18 - LCMRs Sent to Group Practices - The carrier reports the total number of LCMRs sent to group practices of physicians during the reporting period.

Line 19 - LCMRs Sent to All Other Providers - The carrier reports the total number of LCMRs sent to all providers other than individual physicians or group practices of physicians.

Line 20 - Total LCMRs Sent for Period - The system will sum lines 17, 18, and 19 to calculate the total number of LCMRs sent.

280.7 - Sanction Referral Data

(Rev. 6, 08-30-02)
B3-13326.7

Line 21 - SRLs Sent to Individual Physicians - The carrier reports the number of sanction referral letters sent to individual physicians during the reporting period.

Line 22 - SRLs Sent to Group Practices - The carrier reports the number of sanction referral letters sent to group practices of physicians during the reporting period.

Line 23 - All Other Providers - The carrier reports the number of sanction referral letters sent to all providers other than individual physicians or group practices of physicians.

Line 24 - Total SRLs Sent for Period - The system will sum lines 21, 22, and 23 to calculate the total number of sanction referral letters sent.

290 - Completing Health Professional Shortage Area (HPSA) Quarterly Report, Form CMS-1565E - General

(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)

The carriers/Part B MACs prepare and submit to CMS each quarter a report on information regarding incentive payments made to physicians who render covered Medicare services in HPSAs (see Pub. 100-04, Chapter 12, §§90.4 – 90.4.7) on the results of its review of sample claims for HPSA incentive payments processed during the reporting quarter. It submits this report via the Contractor Reporting of Operational Workload Data (CROWD Form S) system no later than the 75th day following the close of the reporting quarter.

290.1 - Heading

(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)

This report is referenced as Form S in the CROWD system. The carrier/Part B MAC completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

290.2 - Checking Reports

(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)

Before submitting Form S to CMS, the carrier/Part B MAC checks for completeness and arithmetical accuracy. It uses the following checklist:

- Line 2 plus line 3 must equal line 1. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this will no longer be applicable.

- Line 5 plus line 6 must equal line 4. Line 2 plus line 3 must equal line 1. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this will no longer be applicable.

- Line 8 must be less than or equal to line 7.

- Line 9 must be greater than or equal to line 7.

- Line 10 must be less than or equal to line 9.

- Line 13 plus line 14 plus line 15 must be less than or equal to line 12.

- Line 16 must be greater than or equal to line 12.

- Line 17 must be less than or equal to line 16.

- Sum of lines 19-30, column 1 must equal line 10.

- Sum of lines 19-30, column 2 must equal line 17.

290.3 - Current Quarter Payments
(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)

The carrier/Part B MAC reports in lines 1-3 the number of physicians receiving incentive payment checks during the current reporting quarter and in lines 4-6 the respective amounts of payment issued.

Note: For data reporting purposes for this report, "physicians" will be defined as NPI/PIN combinations as provided to the carriers/Part B MACs by the Shared System.

Physicians Receiving Checks

Line 1. Total Physicians - total number of physicians receiving incentive payments.

Line 2. Urban HPSAs - number of physicians receiving incentive payments classified as providing services in a HPSA urban setting. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.

Line 3. Rural HPSAs - number of physicians receiving incentive payments classified as providing services in a HPSA rural setting. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.

Amount Of Incentive Payments

Line 4. Total Incentive Payments - total amount of incentive payments issued to physicians.

Line 5. Urban HPSAs - amount of incentive payments issued to physicians for services provided in a HPSA urban setting. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.

Line 6. Rural HPSAs - amount of incentive payments issued to physicians for services provided in a HPSA rural setting. Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.

290.4 - Current Quarter Reviews
(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)

The carrier/Part B MAC reports in lines 7-11 information on physicians identified for review based on data for the current reporting quarter **excluding** those physicians reviewed because they were noncompliant in the previous quarter.

Note: For data reporting purposes for this report, "physicians" will be defined as NPI/PIN combinations as provided to the carriers/Part B MACs by the Shared System.

Line 7. Physicians Reviewed - number of physicians identified for review based on data for the current reporting quarter. The carrier/Part B MAC excludes those physicians reviewed because of noncompliance in the previous quarter.

Line 8. Physicians Paid Incorrectly - number of physicians reviewed on line 7 that incorrectly received an incentive bonus on at least one claim.

Line 9. Claims Reviewed - number of total claims reviewed for physicians reported on line 7.

Line 10. Claims Paid Incorrectly - number of claims included on line 9 where the physician incorrectly received incentive payments.

Line 11. Incentive Amount Paid Incorrectly - total incentive amount incorrectly paid on claims identified on line 10.

290.5 - Prior Quarter(s) Reviews

(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)

The carrier/Part B MAC reports in lines 12-18 information on physicians reviewed because they were noncompliant in the previous quarter(s).

Note: For data reporting purposes for this report, "physicians" will be defined as NPI/PIN combinations as provided to the carriers/Part B MACs by the Shared System.

Line 12. Physicians Reviewed - number of physicians who were identified in lines 8, 13, 14, or 15 on the previous quarter report as noncompliant.

Line 13. Physicians Noncompliant Two Quarters - number of physicians identified in line 12 that were noncompliant in the current and previous quarters, but no quarters prior.

Line 14. Physicians Noncompliant Three Quarters - number of physicians identified in line 12 that were included in line 13 in the previous quarter's report and still noncompliant in the current quarter.

Line 15. Physicians Noncompliant Four or More Quarters - number of physicians identified in line 12 that were included in line 14 in the previous quarter's report and still noncompliant in the current quarter.

Line 16. Claims Reviewed - number of claims reviewed for the physicians identified in line 12.

Line 17. Claims Paid Incorrectly - number of claims in line 16 that were paid incorrectly.

Line 18. Incentive Amount Paid Incorrectly - total incentive amount paid on those claims identified in line 17.

290.6 - Error Descriptions

(Rev. 176, Issued: 11-12-10, Effective: 12-13-10, Implementation: 12-13-10)

This report breaks down the number of claims found to be paid incorrectly by selected error categories for "Current Quarter Reviews" and "Prior Quarter(s) Reviews". Claims counts reported in lines 19-30 under the "Number of Claims Current Quarter" column should total to the number reported in line 10. Similarly, claims counts reported in lines 19-30 under the "Number of Claims Prior Quarter(s)" column should total to the number reported in line 17. In a case where the claim could fall into more than one category, the carrier/Part B MAC makes a determination as to which category to put the claim in. Each claim incorrectly receiving a HPSA incentive payment should be counted only once under the "Error Descriptions" section.

Line 19. Office In, Service Outside HPSA - number of claims where the provider's office is located in a HPSA, but the provider travels to a non-HPSA to provide services.

Line 20. Office Outside, Service Outside HPSA - number of claims where neither the provider's office nor the place of service is located in a HPSA.

Line 21. Multiple Offices, Service Non-HPSA Office - number of claims when the physicians with multiple offices (some of which may be in a HPSA, and some of which are not) bill for services provided in their non-HPSA office.

Line 22. Beneficiary in HPSA, Services Outside HPSA - number of claims where the provider used the beneficiary's address for HPSA incentive eligibility instead of the place of service.

Line 23. Provider Codes Prior to Effective Date HPSA - number of claims where the services were provided before the effective date the area was designated as a HPSA. The effective date providers can begin coding claims for HPSA incentive payments is the first day of the second month following the date CMS is notified by PHS. CMS will transmit the effective date to the carrier/Part B MAC. Effective January 1, 2005, the effective date of a HPSA designation will be the date of the HRSA designation letter which will be reflected on the HRSA Web site.

Line 24. Service Area No Longer HPSA - number of claims requesting HPSA payment after the area is no longer classified as a HPSA. CMS will transmit the termination date to the carrier/Part B MAC.

Line 25. Non-Physician Practitioner - number of claims coded for HPSA incentives, but the services were provided by someone other than a physician. An example is a claim submitted with the HPSA modifier, and the service was provided by a nurse practitioner.

Line 26. Non-Physician Service - number of claims coded for HPSA incentives which were for services other than physician professional services. Examples of services furnished by a physician, but not subject to the HPSA incentive, are technical components of diagnostic tests, drugs, and separately payable supplies.

Line 27. Carrier/Part B MAC Provided Incorrect Information - number of claims that were incorrectly coded by the provider for HPSA incentives as a result of incorrect information the carrier/Part B MAC provided.

Line 28. Carrier/Part B MAC Published Incorrect Notice - number of claims where the provider code for HPSA incentives was based on a population group (noncovered) HPSA notice the carrier/Part B MAC incorrectly published.

Line 29. Carrier Keying/Processing Error - number of claims paid for the HPSA incentives inappropriately due to keying or processing errors made by carrier/Part B MAC staff.

Line 30. Other - number of claims that do not fit into any of the other categories. Although not routinely required, carriers/Part B MACs may be asked to expand on the reason for error on these types of claims.

290.7 - Completing Physician Scarcity Area (PSA) Quarterly Report, Form CMS-1565F, CROWD Report 6

(Rev. 88, Issued: 01-06-06; Effective Date: 01-01-06; Implementation Date: 02-06-06)

The Carriers prepare and submit to CMS each quarter a report on information regarding incentive payments made to physicians who render covered Medicare services in PSA (see Pub. 100-04, Chapter 12, Section 90.5 – 90.5.7) on the results of its review of sample claims for PSA incentive payments processed during the reporting quarter. Carriers shall only review claims that received bonuses based on the use of the “AR” modifier. Carriers shall submit this report via the Contractor Reporting of Operational Workload Data (CROWD Form 1565F, CROWD Form 6) system no later than the 75^{th} day following the close of the reporting quarter. The first report was initiated for the first quarter of 2005.

290.7.1 - Physician Scarcity Area (PSA) Quarterly Report, Line Descriptors

(Rev. 65, Issued: 02-25-05; Effective: 07-01-05; Implementation: 07-05-05)

The carrier reports in lines 1-3 the number of physicians receiving incentive payment checks during the current reporting quarter and in lines 4-6 the respective amounts of payment issued.

Carrier shall report data on Form CMS –1565F, CROWD Form 6 according to the data described below:

Physicians Receiving Checks:
Line 1 = Total of all physicians who received PSA bonus for the quarter
Line 2 = Total of physicians who received the PSA bonus via automated payment
Line3 = Total of physicians who received the PSA bonus for claims reporting the “AR” modifier

Amount of Incentive Payments:
Line 4 = Total of All PSA incentive payments paid for the quarter
Line 5 = Total of PSA incentive payments paid for automated payments
Line 6 = Total of PSA incentive payments paid for claims reporting the “AR” modifier

Current Quarter Reviews:
Line 7 = Number of physicians reviewed
Line 8 = Number of physicians paid incorrectly
Line 9 = Number of claims reviewed
Line 10 = Number of claims paid incorrectly
Line 11 = Total incentive amount paid incorrectly

Prior Quarter(s) Review:
Line 12 = Number of physicians reviewed
Line 13 = Number of physicians reviewed that have been noncompliant for 2 quarters
Line 14 = Number of physicians reviewed that have been noncompliant for 3 quarters
Line 15 = Number of physicians reviewed that have been noncompliant for 4+ quarters
Line 16 = Number of claims reviewed
Line 17 = Number of claims paid incorrectly
Line 18 = Total incentive amount paid incorrectly

290.7.2 - Error Descriptors:
(Rev. 65, Issued: 02-25-05; Effective: 07-01-05; Implementation: 07-05-05)

This report breaks down the number of claims found to be paid incorrectly by selected error categories for "Current Quarter Reviews" and "Prior Quarter(s) Reviews". Claims counts reported in lines 19-30 under the "Number of Claims Current Quarter" column should total to the number reported in line 10. Similarly, claims counts reported in lines 19-30 under the "Number of Claims Prior Quarter(s)" column should total to the number reported in line 17. In a case where the claim could fall into more than one category, the carrier makes a determination as to which category to put the claim in. Each claim incorrectly receiving a PSA incentive payment should be counted only once under the "Error Descriptions" section.

Carriers shall show # of claims in column 1 for current quarter and column 2 for prior quarters for all lines below):

Line 19 = Office in, Service outside of PSA
Line 20 = Office outside, Service outside of PSA
Line 21 = Multi-Office, Service Not-PSA Office
Line 22 = Bene. In PSA, Service outside of PSA
Line 23 = Prov. Code Prior to Eff. Date of PSA
Line 24 = Service Area no Longer PSA
Line 25 = Non-Physician Practitioner
Line 26 = Non-Physician Service
Line 27 = Carrier Provided Incorrect Info.
Line 28 = Carrier Published Incorrect Notice
Line 29 = Carrier Keying/Processing Error
Line 30 = Other

290.8 - Checking Reports
(Rev. 88, Issued: 01-06-06; Effective Date: 01-01-06; Implementation Date: 02-06-06)

Before submitting Form CMS - 1565 F, CROWD Report 6 to CMS, the carrier checks for completeness and arithmetical accuracy. It uses the following checklist:

- Line 2 plus 3 may or may not equal line 1.
  ***NOTE:** Line 1 does not necessarily have to be the sum total of line 2 and line 3. Some physicians will be counted in both categories as receiving the bonus payment via automated payment and/or via reporting the "AR" modifier.

- Line 5 plus line 6 must equal line 4.

- Line 8 must be less than or equal to line 7.

- Line 9 must be greater than or equal to line 7.

- Line 10 must be less than or equal to line 9.

- Line 13 plus line 14 plus line 15 must be less than or equal to line 12.

- Line 16 must be greater than or equal to line 12.

- Line 17 must be less than or equal to line 16.

- Sum of lines 19-30, column 1 must equal line 10.

- Sum of lines 19-30, column 2 must equal line 17.

300 - Exhibits

(Rev. 6, 08-30-02)
B3-13329

Exhibit 1 - Medicare Program Quarterly Supplement To The Carrier Performance Report CMS-1565a (Crowd Form A)

MEDICARE PROGRAM QUARTERLY SUPPLEMENT TO THE CARRIER PERFORMANCE REPORT CMS-1565A (CROWD FORM A)

CARRIER			**REPORTING PERIOD (QUARTER AND YEAR)**
	NUMBER AND TYPE OF CLAIM		
REPORTING ITEM	**TOTAL - 1**	**ASSIGNED - 2**	**UNASSIGNED - 3**
A. CLAIMS REDUCED OR DENIED COVERED CHARGES 1. Tot. Cvrd. Charges For All Claims			
REAS. CHG./FEE SCHED.			

REDUCTIONS 2. No. of Clms w/Reas Chg/Fee Sched Red			
3. Amount of Reduction (in $)			
MEDICAL NECESSITY REDUCTIONS 4. Number of Claims w/ Med. Nec. Red.			
5. Amount of Reduction (in $)			
GLOBAL FEE/REBUNDLING REDUCTIONS 6. No. of Claims w/ Glo. Fee/Rebun Red.			
7. Amount of Reduction (in $)			
DENIALS 8. Claims Denied in Full or in Part 9. Amount Disallowed (in $)			
REASONS FOR DENIAL	NUMBER OF ITEMS DENIED (1)	AMOUNT DISALLOWED (2)	NUMBER OF CLMS DENIED (3)
10. Claimant Ineligible			
11. Filing Limitation Exceeded			
12. Duplicate Claim			
13. Services Not Covered			
14. Services Not Medically Necessary			
15. MSP			
16. Missing Information			
17. Global Fee/Rebundling			
18. Other			
19. Total			

FORM-CMS 1565A

Exhibit 2 - Medicare Fraud Unit Quarterly Workload Status Report - CMS-1565B (CROWD FORM M)

MEDICARE FRAUD UNIT QUARTERLY WORKLOAD STATUS REPORT
CMS-1565B (CROWD FORM M)

CARRIER NUMBER______________________________
REPORT PERIOD_________________________________

FRAUD WORKLOAD ITEM	**TOTAL** **1**	**BENEFICIARY COMPLAINT** **2**	**OIG HOTLINE** **3**	**REFERRAL & OTHERS** **4**
1. OPENING PENDING				
2. ADJUSTMENTS				
3. ADJUSTED PENDING				
4. WORKLOAD RECEIVED				
5. TOTAL CLEARED				
6. BY CONTRACTOR				
7. BY REFERRAL				
8. CLOSING PENDING				

FORM-CMS 1565B

Exhibit 3 - Medicare Program Quarterly Supplement To The Carrier Performance Report CMS-1565C (Crowd Form G)

MEDICARE PROGRAM QUARTERLY SUPPLEMENT TO THE CARRIER PERFORMANCE REPORT CMS-1565C (CROWD FORM G) CARRIER REPORTING PERIOD

REPORTING ITEM	TOTAL 1	NON-PAR ASSIGNED 2	NON-PAR UNASSGNED 3	PARTICI-PANTS 4
1. CLAIMS APPROVED: TOTAL				
2. PHYS ONLY				
3. PHYS AND NONPHYS				
4. NONPHYS ONLY				
5. COVRD SERVICES: NUMBER				
6. PHYS				
7. NONPHYS				
8. AMT COVRD CHRGS: TOTAL				
9. PHYS				
10. NONPHYS				
11. CLAIMS REDUCED: TOTAL				
12. PHYS ONLY				
13. PHYS AND NONPHYS				
14. NONPHYS ONLY				
15. COVRD SRVCS RED: NUM				
16. PHYS				
17. NONPHYS				
18. AMOUNT REDUCED: TOTAL				
19. PHYS				
20. NONPHYS				
21. FULL DENIALS: NUMBER				
22. PHYS ONLY				
23. PHYS AND NONPHYS				
24. NONPHYS ONLY				
25. FULL/PART DENIALS: NUM				
26. PHYS ONLY				
27. PHYS AND NONPHYS				
28. NONPHYS ONLY				
29. DENIED SERVICES: NUM				
30. PHYS				
31. NONPHYS				
32. AMT DISALLOWED: TOTAL				

33. PHYS				
34. NONPHYS				

FORM-CMS 1565C

Exhibit 4 - Comprehensive Limiting Charge Compliance Program Quarterly Report CMS-1565d (Crowd Form N)

COMPREHENSIVE LIMITING CHARGE COMPLIANCE PROGRAM QUARTERLY REPORT - CMS-1565D (CROWD FORM N)

CARRIER NUMBER________________ REPORT PERIOD___________________

	COLUMN 1	**COLUMN 2**
1. LCERs SENT TO IND PHYSICIANS 2. LCERs SENT TO GROUP PRACTICES 3. LCERs SENT TO ALL OTHER PROVIDERS 4. TOTAL LCERs SENT FOR PERIOD 5. TOTAL CLAIMS ON LCERs SENT 6. CLAIMS SELECTED FOR VERIFICATION 7. BENEFICIARIES W/CLAIMS ON LCERS 8. TOTAL DOLLARS ALLOWED 9. DOLLARS IN ECESS OF LMTNG CHARGE		
10. $1.00-$4.99 11. $5.00-$499.99 12. $500+ 13. TOTAL	# OF PROCEDURES	TOTAL $ VALUE
14. VERIFICATIONS POSTED TO LCEF 15. NOT REQUESTED ON LCER 16. UNACCEPTABLE VERIFICATIONS		
17. LCMRs SENT TO IND PHYSICIANS 18. LCMRs SENT TO GROUP PRACTICES 19. LCMRs SENT TO ALL OTHER PROVIDERS 20. TOTAL LCMRs SENT FOR PERIOD 21. SRLs SENT TO IND PHYSICIANS 22. SRLs SENT TO GROUP PRACTICES 23. SRLs SENT TO ALL OTHER PROVIDERS 24. TOTAL SRLs SENT FOR PERIOD		

FORM-CMS 1565D

Exhibit 5 - Health Professional Shortage Area (HPSA) Quarterly Report

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) QUARTERLY REPORT CMS-1565E (CARRIERS ONLY - CROWD FORM S)

Screen 1

CARRIER NAME______________________________

CARRIER NUMBER____________________________

CMS-1565E REPORT PERIOD____________________
CURRENT QUARTER PAYMENTS
PHYSICIANS RECEIVING CHECKS:

1. TOTAL
2. URBAN HPSA'S
3. RURAL HPSA'S

AMOUNT OF INCENTIVE PAYMENTS:

4. TOTAL
5. URBAN HPSA'S
6. RURAL HPSA'S

Exhibit 6 - Health Professional Shortage Area (HPSA) Quarterly Report CMS-1565E (Carriers Only - Crowd Form S)

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) QUARTERLY REPORT CMS-1565E (CARRIERS ONLY - CROWD FORM S)

Screen 2

CARRIER NAME CMS-1565E

CARRIER NUMBER REPORT PERIOD

CURRENT QUARTER REVIEWS

7. PHYSICIANS REVIEWED
8. PHYSICIANS PAID INCORRECTLY
9. CLAIMS REVIEWED
10. CLAIMS PAID INCORRECTLY
11. INCENTIVE AMOUNT PAID INCORRECTLY

PRIOR QUARTER(S) REVIEWS

12. PHYSICIANS REVIEWED
13. PHYSICIANS NONCOMPLIANT 2 QRTS.
14. PHYSICIANS NONCOMPLIANT 3 QRTS.
15. PHYSICIANS NONCOMPLIANT 4+ QRTS.
16. CLAIMS REVIEWED
17. CLAIMS PAID INCORRECTLY
18. INCENTIVE AMOUNT PAID INCORRECTLY

Exhibit 7 - Health Professional Shortage Area (HPSA) Quarterly Report

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) QUARTERLY REPORT - CMS-1565E (CARRIERS ONLY - CROWD FORM S)

Screen 3

CARRIER NAME ___________________ CMS-1565E
CARRIER NUMBER _________________ REPORT PERIOD ________________

ERROR DESCRIPTIONS	# OF CLAIMS CURENT QUARTER	# OF CLAIMS PRIOR QUARTER.
19. OFFICE IN, SERVICE OUTSIDE HPSA		
20. OFFICE OUTSIDE, SERV. OUTSIDE HPSA		
21. MULTI-OFFICE, SERVICE NON-HPSA OFF.		
22. BENE. IN HPSA, SERVICE OUTSIDE HPSA		
23. PROV. CODE PRIOR TO EFF. DATE HPSA		
24. SERVICE AREA NO LONGER HPSA		
25. NON-PHYSICIAN PRACTITIONER		
26. NON-PHYSICIAN SERVICE		
27. CARRIER PROVIDED INCORRECT INFO.		
28. CARRIER PUBLISHED INCORRECT NOTICE		
29. CARRIER KEYING/PROCESSING ERROR		
30. OTHER		

310 - Carrier Beneficiary Overpayment Activity Report (Form CMS-2174) - General

(Rev. 6, 08-30-02)
B3-13350

At the end of each calendar quarter (i.e., December, March, June, September) the carrier prepares and submits to CMS a report summarizing beneficiary overpayment activity completed during the reporting quarter. It completes a separate report for each carrier office that has been assigned a separate carrier number.

310.1 - Purpose and Scope

(Rev. 6, 08-30-02)
B3-13350.1

This report provides CMS with current data on beneficiary overpayments - nationally as well as for each carrier. The report enables CMS to tabulate for administrative and statistical purposes data on beneficiary overpayments:

- The total dollar amount of money overpaid;
- The causes of overpayments;
- How overpayments are discovered; and
- The amount of overpayments you recover.

310.2 - Due Date

(Rev. 6, 08-30-02)
B3-13350.2

The carrier transmits the CMS-2174 to CO via PC or terminal as soon as possible after the end of the reporting quarter, but no later than the 15th day of the month following the end of the reporting quarter, e.g., the October-December report is due on January 15. Non-receipt of the report by the due date will result in CMS contacting it to obtain the required information.

320 - Completing Carrier Beneficiary Overpayment Activity Report

(Rev. 6, 08-30-02)
B3-13351

320.1 - Classification of Claims for Counting

(Rev. 6, 08-30-02)
B3-13351.1

Data on the CMS-2174 reflects counts of **claims** for which the carrier has made a determination that a beneficiary-recoverable overpayment exists. The overpayment must have been made to a beneficiary or to a without-fault physician/supplier on behalf of a beneficiary. The carrier should not confuse this with an assignee overpayment (i.e., one made to an assignee who is at fault and therefore liable). (See Chapter 3, §§200-202.) It counts claims only once regardless of the number of separate instances of overpayments found on them.

330 - Completion of Items on Form CMS-2174

(Rev. 6, 08-30-02)
B3-13360

330.1 - Heading

(Rev. 6, 08-30-02)
B3-13360.1

The carrier enters its ID number in the number box. In the space labeled "Reporting Period" it enters the fiscal quarter and year (e.g., 0190 for October-December 1989) for which the report is prepared.

330.2 - Section A - Beneficiary Overpayments

(Rev. 6, 08-30-02)
B3-13360.2

The carrier reports the number of claims and the dollar amounts for which a determination was made during the reporting quarter or a previous quarter that a beneficiary-recoverable overpayment had been made. It does not count potential overpayment claims under investigation. It includes **individual** overpayments discovered as part of CMS's Carrier Quality Control Program (QA) end-of-line review sample. It does not include projections of overpayments from QA samples. It includes overpayments discovered where Medicare is secondary to prime insurers (Department of Labor - BL, WC, VA, auto medical or no fault, liability, EGHP under the working aged or ESRD provisions or LGHP under the disabled provision) that also paid the beneficiary.
Round amounts to the nearest whole dollar.

Line 1. Pending Start of Quarter - The number of claims and dollar amount of beneficiary overpayments reported in line 13 as the closing pending on the previous quarter's report.

Line 2. Adjustments to Opening Pending - Any adjustments to the previous quarter's closing pending amount due to errors, decisions resulting from reviews and hearings, reopenings, etc. Show as a plus or a minus, as appropriate.

Line 3. Adjusted Opening Pending - The result of line 1 + line 2, as appropriate.

Line 4. Discovered During Reporting Quarter - The number of claims and the dollar amount for which a determination was made **during the reporting quarter** that a beneficiary-recoverable overpayment had been made. This does not include potential overpayments under investigation. It includes claims where the payee returned or never negotiated the check(s).

Claim counts are treated differently from money amounts in lines 5-9 below. A claim is counted in these lines only when it has been fully disposed. **This line does not** include partial dispositions in the claim counts for lines 5-9. **It does not include** any money amounts partially disposed in lines 5-9 as appropriate.

Line 5. Dispositions - The number of claims for which:
Recovery of a beneficiary-recoverable overpayment by offset or refund was **completed during the quarter** (see NOTE 3); or

A determination was made during the quarter that the overpayment is uncollectible or is to be abandoned in accordance with Chapter 3, §§190 ff.

This includes any amount recouped by offset or refund, or determined to be uncollectible or abandoned in accordance with Chapter 3, §§190 ff. during the quarter, regardless of whether it was a full or partial determination.

NOTES:

1. If part of an overpayment is recouped and the remainder is determined to be uncollectible or abandoned, the disposition of the overpayment is considered to be completed.
2. If the disposition of the overpayment is completed and it falls into more than one line of lines 7, 8, 10-12, it is counted once under the "number of claims" in the line category accounting for the greatest dollar amount. The carrier reports the money amount in each appropriate line, however. (It does not report any money amounts reported in previous quarters.)
3. If part of the overpayment has been recouped and part is still outstanding at the end of the quarter, the carrier includes the amount recouped. **It does not include the claim count**. It includes the portion of the overpayment which is still outstanding in the claim count and amount for line 10.

Line 6. Collected - The carrier enters the number of overpayments recouped by offset or refund during the reporting quarter. Under the money column, it reports any amount recovered by offset or refund.

Line 7. Recouped by Offset - The carrier enters the number of beneficiary-recoverable overpayment claims for which it completed disposition during the reporting quarter and for which most or all of the dollar amounts were recouped by offsetting payment on subsequent requests for payment. (This includes cases where a letter has been written to the payee requesting a refund, but before the refund is received a request for payment is received which completes repayment of the overpayment.) Under the money amount column, it reports any amount recovered by this method, whether a full or partial recovery.

Line 8. Recouped by Refund - The carrier enters the number of beneficiary-recoverable overpayment claims for which it completed disposition during the reporting quarter and the final disposition was made by a refund. (It includes cases where the payees returned the checks.) Under the money amount column, it reports any amount recovered by refund, whether a full or partial recovery.

Line 9. Uncollectibles - The carrier reports the number of beneficiary-recoverable overpayment claims for which it completed disposition during the reporting quarter by determining for most or all of the dollar amount, to be uncollectible and have either referred to the RO, waived, or abandoned them. Under the money column, it reports the amount involved.

Line 10. Referred to RO - The carrier enters the number of beneficiary-recoverable overpayment claims for which it completed disposition during the reporting quarter and where, for most or all of the dollar amount, it terminated recovery efforts and referred the claim to the RO. (See Chapter 3, §§190 ff.) Under the money amount column, it reports the amount referred to RO.

Line 11. Waived by Contractor - The carrier enters the number of beneficiary-recoverable overpayment claims for which it completed disposition during the reporting quarter and where it waived most or all of the dollar amounts. (See Chapter 3, §§190 ff). Under the recovery amount column, it reports any amount waived in this way during the quarter.

NOTE: A waiver is a case in which the beneficiary is liable and the criteria in Chapter 4, §100B for waiver recovery is met; i.e., it appears from the circumstances of the overpayment that the beneficiary was without fault and that the recovery would be against equity and good conscience or would defeat the purpose of the Medicare Program (i.e., cause the individual financial hardship).

Line 12. Abandoned in Accordance with Manual Instructions - The carrier enters the number of beneficiary-recoverable overpayment claims for which it completed disposition during the reporting quarter and which it abandoned for most or all of the dollar amount in accordance with Chapter 4, §70. Under the money amount column, it reports any amount abandoned.

A claim is abandoned when recovery has been terminated because:

- The total overpayment is less than $50,
- The carrier has not taken action to reopen the payment decision within 4 years (48months) after the date of the initial payment determination,
- Deceased beneficiary has no estate and there are no surviving relatives, or Beneficiary is on public assistance

Line 13. Pending End of Quarter - The carrier enters the number of beneficiary-recoverable overpayments claims with any amount outstanding at the end of the reporting quarter. If part of a claim is recouped and part is outstanding, it reports only the amount outstanding. It does not include any amounts which have been recouped, either in full or in part.

330.3 - Section B - Cause of Overpayments

(Rev. 6, 08-30-02)
B3-13360.3

This solicits the reasons for overpayments in which a determination was made **during the quarter** that an overpayment had been made to, or on behalf of, the beneficiary. The data include both the number of claims on which beneficiary-recoverable overpayments were discovered and the amount of overpayment (not over-allowance) involved.

Where more than one cause of overpayment exists, the carrier reports the claim and dollar amount of the overpayment on only one of the lines 14 through 23 according to the principal reason for overpayment. The principal reason is that which involves the greatest dollar amount.

The number of claims and amounts of beneficiary overpayments for reasons 14 through 23 combined should equal the number of claims and amount reported in Section A on line 4.

Line 14. Beneficiary Not Entitled - The carrier enters under the appropriate columns the number and dollar amount of overpayments which resulted because payments were made to, or on behalf of, a beneficiary for services rendered during a period of non-entitlement or for claims processed under the wrong HICN. (See Medicare Carrier Quality Assurance Handbook §290.1).

Line 15. Services Not Covered - The carrier enters the number and dollar amount of overpayments which resulted because payments were made for non-covered services other than medically unnecessary services. (See Medicare Carrier Quality Assurance Handbook §290.2).

Line 16. Charge Exceeded Reasonable Charge - The carrier enters under the appropriate columns the number and dollar amount of overpayments which resulted when improper charges, higher than the reasonable charge amount, were allowed. (See Medicare Carrier Quality Assurance Handbook §290.3).

Line 17. Payment Made to Wrong Payee - The carrier enters under the appropriate columns the number and dollar amount of overpayments which resulted when a person other than the proper payee received the payment (e.g., the beneficiary is paid on an assigned claim). It reports duplicate payments made to the wrong payee in line 18 instead of here.

Line 18. Duplicate Payment - The carrier enters under the appropriate columns the number and dollar amount of overpayments which occurred when payment was made to, or on behalf of, the beneficiary more than once for the same service.

Line 19. Medically Unnecessary Services - The carrier enters under the appropriate columns the number and dollar amount of overpayments discovered which arose because of payments for services later determined to be medically unnecessary.

Line 20. Services Not Rendered - The carrier enters under the appropriate columns the number and dollar amount of overpayments discovered which arose because of payments for services not actually rendered. It includes claims which involve forgery or fraudulent billing for noncovered services and other identified program abuses.

Line 21. Medicare Secondary Payor - The carrier enters under the appropriate columns the number and dollar amounts of overpayments which arose because Medicare is secondary to prime insurers (e.g., Department of Labor, BL, WC, VA, auto, medical or no fault, liability, EGHP under the working aged or ESRD provision or LGHP under the disabled provision).

Line 22. Documentation/Coding/Data Entry - The carrier enters under the appropriate columns the number and dollar amount of overpayments which resulted from:

- Insufficient documentation to support the payment action. (This could involve a claims processor's failure to resolve questions concerning entitlement, coverage, utilization, or reasonable charge)

- Incorrect or incomplete coding; and

- Errors in the transferring of data from an external document into a machine readable form, including errors in keypunching and other methods for data entry. (See Medicare Carrier Quality Assurance Handbook §§210.5-210.6).

NOTE: If a documentation/coding data entry error results in an overpayment which may be categorized into any of lines 14 - 21, the carrier uses one of lines 14 - 21 instead of using line 22.

Line 23. Other - The carrier enters under the appropriate columns the number and dollar amount of overpayments discovered which are not specifically provided for in lines 14-22 above.

330.4 - Section C - How Overpayments Were Discovered

(Rev. 6, 08-30-02)
B3-13360.4

This shows data on beneficiary-recoverable overpayments according to how they were discovered. Where more than one method of discovery exists, the carrier reports the claim and dollar amount of overpayment on only one of lines 24 - 28 according to the principal method of discovery. The principal method is that which involves the greatest dollar amount.

Line 24. Reported by Beneficiary or Provider - The carrier enters under the appropriate columns the number of overpayments and that part of the dollar amount reported on line 4 which were discovered when a beneficiary or provider reported a beneficiary-recoverable overpayment. (This includes the situation where the beneficiary was paid instead of the provider.)

Line 25. CMS's Carrier Quality Control Program - The carrier enters under the appropriate columns the number of overpayments and that part of the dollar amount reported on line 4 which were discovered through CMS's Carrier Quality Control Program - including both the carrier sample and the RO sub-sample.

Line 26. Carrier Internal Audit or Review - The carrier enters under the appropriate columns the number of overpayments and that part of the dollar amount reported on line 4 which were discovered through its internal auditing procedures or review of subsequent claims. It **excludes** cases where the overpayment was discovered through CMS's Carrier Quality Control Program. (See line 25.)

Line 27. Government Agency - The carrier enters under the appropriate columns the number of overpayments and that part of the dollar amount reported on line 4 which were discovered by DHHS, GAO, OIG, or other government agency audit.

Line 28. Other Methods of Discovery - The carrier enters under the appropriate columns the number and dollar amounts involved for overpayments discovered by methods.

The number and amount of beneficiary overpayments reported on lines 24 through 28, when combined, should equal the number and amount reported in Section A on line 4.

330.5 - Checking Reports Prior to Submittal to CMS

(Rev. 6, 08-30-02)

B3-13360.5

Before sending reports to CMS, the carrier checks for completeness and arithmetic accuracy. The following checklist assists in the arithmetic check for both the number of claims and the amount of money involved.

- A valid 5-digit carrier number is required.
- The default value for areas not keyed is zero.
- Appropriate fiscal quarter (1-4) and year is required.
  - For each column, line 1, plus or minus line 2, must equal line 3. Line 3cannot be negative.
  - For each column line 6 + 9 must equal line 5.
  - For each column line 7 + 8 must equal line 6.
  - For each column line 10 + 11 + 12 must equal line 9.
  - For each column line 3 + 4 - 5 must equal line 13.
  - For each column line 14 + 15 + 16 + 17 + 18 + 19 + 20 + 21 + 22 + 23 must equal line 4.
  - For each column line 24 + 25 + 26 + 27 + 28 must equal line 4.
  - For each column line 1 of the current report must equal line 13 of the previous report.

340 - Exhibit - Medicare Program Carrier Beneficiary Overpayment Activity Report - (Form CMS-2174)

(Rev. 6, 08-30-02)

B3-13379

MEDICARE PROGRAM CARRIER BENEFICIARY OVERPAYMENT ACTIVITY REPORT

CARRIER NUMBER ________________ REPORTING PERIOD ______________

	NUMBER OF CLAIMS	**AMOUNT OF MONEY**
A.BENEFICIARY OVERPAYMENTS		
1. PENDING START OF QUARTER		
2. ADJUSTMENTS TO OPENING PENDING		
3. ADJUSTED OPENING PENDING		
4. DISCOVERED DURING REPORTING QUARTER		
5. DISPOSITIONS		
6. COLLECTED		
7. RECOUPED BY OFFSET		
8. RECOUPED BY REFUND		
9. UNCOLLECTIBLES		
10. REFERRED TO REGIONAL OFFICE		
11. WAIVED BY CONTRACTOR		
12. ABANDONED IN ACCORD WITH MAN. INSTR.		
13. PENDING END OF QUARTER		
B. CAUSE OF OVERPAYMENTS		
14. BENEFICIARY NOT ENTITLED		
15. SERVICES NOT COVERED		
16. CHARGE EXCEEDED REASONABLE CHARGE		
17. PAYMENT MADE TO WRONG PAYEE		
18. DUPLICATE PAYMENT		
19. MEDICALLY UNNECESSARY SERVICES		

	NUMBER OF CLAIMS	**AMOUNT OF MONEY**
20. SERVICES NOT RENDERED		
21. MEDICARE SECONDARY PAYER		
22. DOCUMENTATION/CODING/DATA ENTRY		
23. OTHER		
C. HOW OVERPAYMENTS WERE DISCOVERED		
24. REPORTED BY BENEFICIARY OR SUPPLIER		
25. CMS's CARRIER QUALITY CONTROL PROGRAM		
26. CARRIER INTERNAL AUDIT OR REVIEW		
27. GOVERNMENT AGENCY		
28. OTHER METHODS OF DISCOVERY		

Monthly Statistical Report on Carrier Appeal Activity

350 - Carrier Appeals Report (Form CMS-2590)
(Rev. 6, 08-30-02)
B3-13400

At the end of each month the carrier prepares and transmits to CMS a report summarizing its Part B review and hearing activity during the month. The carrier completes a separate report for each office assigned a separate carrier number.

Form CMS-2590 is subject to the Paperwork Reduction Act and requires approval from the Office of Management and Budget (OMB). OMB approval has been requested.

350.1 - Purpose and Scope
(Rev. 6, 08-30-02)
B3-13400.1

The CMS-2590 (see §300 - Exhibits 1 through 4) provides CMS with the basic data needed on review and hearing (both carrier and ALJ) activity. This report enables CMS to tabulate data for administrative purposes on the following information:

- The number of reviews and hearings requested, completed, and pending;
- The number of reviews and hearings resulting in affirmations or reversals of previous determinations;
- The number of reviews and hearings involving waiver of liability determinations and dollar amount of charges allowed;
- Data on timeliness; and
- The number of Part B reopenings.

350.2 - Due Date
(Rev. 6, 08-30-02)
B3-13400.2

The carrier transmits form CMS-2590 to CO via PC or terminal. It uses instructions in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.

The report is due as soon as possible after the end of the reporting month but no later than the 15th of the month following the end of the reporting month.

360 - Completion of Items on Form CMS-2590
(Rev. 6, 08-30-02)
B3-13410

360.1 - Heading

(Rev. 6, 08-30-02)
B3-13410.1

The carrier enters its ID number in the space provided. In addition, it indicates the reporting month, i.e., 0202 for February 2002.

360.2 - Section A - Carrier Appeal Requests

(Rev. 6, 08-30-02)
B3-13410.2

Section A: Carrier Appeal Requests - This part concerns data from the Part B appeals process. The number of appeals requested (received), completed, and pending reflects the status of the workload as of the last day of the reporting month. The carrier bases data on actual counts of each activity and not on sampling or other estimating techniques.

APPEALS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) Total Reviews - The first formal level of appeal following denial of a Part B claim. It is a second look by a different employee at the claim and supporting evidence. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals). The carrier does not count duplicate review requests or review requests received before it has made an initial determination on a claim. It counts one review per request received. With the exception of line 7, it does not count the number of claims or beneficiaries involved in the requests. It reports in Column (1) data relating to all types of reviews (both those requested in writing and those conducted by telephone).

Column (2) Telephone Reviews - The carrier reports in this column, data on those reviews included in column 1 that were conducted by telephone. It reports data in this column on lines 6, 7, 9, 10, 11, and 12 only.

Column (3) Carrier Hearings - This column represents independent determinations on claims for which the party has appealed the carrier review decision. Such independent determinations are rendered by Hearing Officers (HO) that the carrier assigns. The amount in controversy must be at least $100. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals)

The carrier counts one hearing per request received (i.e., form CMS-1965 or equivalent written request). It includes hearings requested that do not meet the minimum $100 requirements and are subsequently dismissed. With the exception of line 7, it does not count the number of claims or beneficiaries involved in the requests. (It reports claim counts in line 7.) It does not count hearing requests that qualify for an ALJ hearing (i.e., Part B hearings are those hearings that a hearing officer adjudicates, as opposed to an ALJ). See definition for Section D.

It does not count requests for HO hearings received after it has rendered an OTR decision in lines 1-32 of the report. It counts these cases only in lines 33, 34, 35, 36, and 38 as appropriate.

Line 1. Opening Pending - It enters, under the appropriate columns, the numbers of reviews on line 18 and hearings reported on line 28 as the closing pending on the previous month's report.

Line 2. Adjustments to Pending - If it is necessary to revise the pending figure for the close of the previous month because of inventories or reporting errors, the carrier enters the adjustment. It reports requests received near the end of the reporting month and placed under control sometime after the reporting month as received in the reporting month, not as requests received in the subsequent month. If some cases were not counted in the proper month's receipts, it counts them as adjustments to the opening pending in the subsequent month.

If line 3 of the current month differs from the closing pending of the previous month, there must be an entry in line 2 for the current month. The carrier precedes the entry by a "+" or "-," as appropriate.

Line 3. Adjusted Pending - It enters the result of line 1 + line 2 (taking into account the "-" sign, if any).

Line 4. Requests Received - It enters, under the appropriate columns, the number of review and hearing requests received during the reporting month. (See definitions for columns 1 and 3 for a discussion of what constitutes a request for a review and hearing.) It includes requests transferred to it by other contractors if it incurs the administrative costs for processing the appeals, and reports the costs on the Interim Expenditure Report (Form CMS-1524).

If one physician submits one request involving several assigned claims (and several beneficiaries), the carrier counts this as one request. If one beneficiary submits a request involving several unassigned bills (from several different physicians), it counts this as one request. If an appellant submits more than one request (for different claims) at different times, the carrier counts each request.

NOTE: See definition of column (3) for instructions on hearings requested subsequent to OTR decisions.

Line 4 A. Medical Necessity Documentation Denials - The carrier enters the number of requests included in line 4 that involved initial claim denials for lack of medical documentation.

Line 5. Transferred - The carrier reports, under column 1, the number of review requests it transferred to other carriers because it did not process the original claim(s). It reports, under column 3, the number of hearing requests transferred to other carriers because the claimant is not within the original carrier's geographical area, or the claim was transferred to ROs because the issues are outside the HO's responsibility. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals) For columns 1 and 3, if it reported a review or hearing as transferred, it does not report any information regarding it on lines 6-39. The transfer is the final action.

Line 6. Requests Cleared - The carrier reports, under the appropriate columns, the total number of all reviews, telephone reviews, and hearings completed during the month. It reports all completed reviews and hearings, regardless of the final outcome, i.e., affirmation, reversal, withdrawal, or dismissal. It considers a review cleared when the final determination (EOMB or other notice - including dismissal) is printed or typed, or upon notification of withdrawal by the appellant. In the case of a reversal, it considers the case cleared when it initiates the adjustment action.

A hearing is cleared when the decision is signed, or one of the following conditions is present:

- The claimant indicates satisfaction with the OTR decision;

- The claimant indicates after the OTR decision the desire to proceed with an ALJ hearing (if the amount in controversy is $500 or more);

- The HO dismisses the hearing request; or

- The appellant withdraws the hearing request.

The carrier does not consider a hearing completed upon release of an OTR decision unless the appellant specifically requested an OTR hearing. It does not count the OTR hearing as completed until it has completed all follow-up actions as required in The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals. If, as a result of follow-up actions, the appellant requests an in-person or telephone hearing after release of the OTR decision, the OTR hearing and decision are not counted on the report with the exception noted below. If the appellant does not appear for the subsequent hearing, the hearing is dismissed. The dismissal is the final action. However, the decision to record in lines 9-11 is the OTR decision.

NOTE: If the carrier closes a review or hearing after the end of a reporting month, but before the report is due on the fifteenth of the subsequent month, it does not count it until the subsequent month's report.

Line 7. No. of Claims Involved - The carrier enters the total number of claims (as defined in §§3000-3000.2) involved in the appeals reported as cleared during the month on line 6. For example, if it processes decisions for two hearings in the month, one of which involved three claims, and the other involved seven claims, it reports 10 claims under column 3.

Line 8. Amount in Controversy - For the hearings reported as affirmed (line 9) or reversed (line 11), during the month, the carrier shows the total dollar amount in controversy on the initial hearing request. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals on how to determine the amount in controversy.) It shows results rounded to the nearest dollar.

Line 9. Affirmations - Under the appropriate columns, the carrier shows the number of all reviews, telephone reviews, and hearings completed during the month in which the previous determination was completely upheld, e.g., no change was made. All parts of all claims in a case must be upheld in order to be counted as an affirmation. An OTR hearing decision does not count as a previous decision if the appellant subsequently requests an in-person or telephone hearing. If the in-person/telephone hearing is dismissed because the appellant did not appear, or the request was withdrawn, the carrier uses the OTR decision to determine if the case is counted here.

See line 11 for partial affirmations. (They are not included here.)

If the carrier upholds its original determination, but pays under limitation of liability, it counts the review or hearing determination as an affirmation. It reports the appropriate information in Section D.

Line 10. Dism./Withdr - The carrier reports, under the appropriate columns, the number of all reviews, telephone reviews, and hearings that were withdrawn by the appellant or dismissed (before determination) by the carrier or the HO. It reports here and in lines 4 and 6 an appeal that is requested and withdrawn or dismissed within the same month. If the appellant requests an in-person or telephone hearing after receiving an OTR decision and the carrier dismisses the hearing because the appellant failed to appear, the OTR decision is the final decision, not the dismissal. Similarly, for a withdrawal, the OTR decision is used.

A dismissal at the review level is done when written correspondence or a telephone conversation has been identified as a review request, but the claimant does not have the right to an appeal. Misrouted correspondence is not a dismissal. If the carrier has incorrectly counted such correspondence as a review on a previous report, it uses line 2 (adjustments to pending) to correct the count. It does not count a duplicate request for review on the report. Likewise, it does not count on the report a request for review received before an initial claim determination has been rendered. (It considers the request an inquiry.)

Line 11. Reversals (Full or Part) - Under the appropriate columns, the carrier shows the number of all reviews, telephone reviews, and hearings completed during the month in which at least part of the prior determination was reversed (e.g., a change was made and some or all of the new determination was in favor of the appellant). For example, if a review or hearing involves several claims, and the initial determinations for some of the claims are affirmed and some are reversed, the review or hearing decision is a reversal. An OTR hearing decision does not count as a previous decision if the appellant subsequently requests an in-person or telephone hearing. If the in-person/telephone hearing is dismissed because the appellant did not appear, or the request was withdrawn, the carrier uses the OTR decision to determine if the case is counted here.

Line 12. Amount Awarded - For cases included in line 11 where the issue on the appeal was not a reasonable charge determination, the carrier shows the amount of allowed charges for services where the determination was reversed. It shows charges after reasonable charge reductions, but prior to application of deductible and coinsurance amounts. If the issue was a reasonable charge reduction, it shows the additional amount allowed. It rounds results to the nearest dollar.

Computing Time to Process Carrier Reviews for Lines 13-17

For lines 13-17, the carrier uses the matrix below to determine the number of days from receipt to completion of all reviews (both written and telephone). The date of receipt in all written review requests is the day the processing carrier received it in its corporate mailroom. The date of receipt in all telephone review requests is the day the processing carrier received the request on the dedicated lines or in the dedicated area.

Situation	**Date Completed**
The appellant withdraws the request	The date the carrier is notified of the withdrawal
Carrier dismisses the request or affirms the original determination	The date of the notice

Carrier processes the request to reversal	The date the carrier initiates the adjustment request

Line 13. Review Processing Time - Average - The average number of days from receipt of the review request to the date of completion for all review requests (both written and telephone).

To compute the average number of days from request to completion, the carrier divides the total days elapsed for all requests cleared in the month by the number of requests cleared. It rounds results to the nearest day. It calculates the days elapsed for an individual request by subtracting the Julian date of receipt of the request from the Julian date of completion.

If the request is cleared in the year following the year of receipt, the carrier adds 365 or 366 to the result, as appropriate. (Otherwise, it will get a negative number.) If a case is cleared the same day it is received, it considers the case to require one day.

NOTE: The carrier includes all cases cleared regardless of whether they were affirmed, reversed, dismissed, or withdrawn.

Line 14. Reviews Completed in 1-30 Days - The number of reviews that required 1-30 days to complete. If a case is cleared the same day it is received, the carrier considers it to require 1 day.

Line 15. Reviews Completed in 31-45 Days - The number of reviews that required 31-45 days to complete.

Line 16. Reviews Completed in 46-60 Days - The number of reviews that required 46-60 days to complete.

Line 17. Reviews Completed Over 60 Days - The number of reviews that required more than 60 days to complete.

Line 18. Closing Pending-Reviews - The total number of reviews that have not been completed by the end of the reporting month.

Line 19. Reviews Pending 1-30 Days - The number of reviews included in line 18 that have been pending 1-30 days, inclusive, at the end of the reporting month.

Line 20. Reviews Pending 31-45 Days - The number of reviews included in line 18 that have been pending 31-45 days, inclusive, at the end of the reporting month.

Line 21. Reviews Pending 46-60 Days - The number of reviews included in line 18 that have been pending 46-60 days, inclusive, at the end of the reporting month.

Line 22. Reviews Pending Over 60 Days - The number of reviews included in line 18 that have been pending more than 60 days at the end of the reporting month.

Computing Time to Process Carrier Hearings for Lines 23-27

For lines 23-27, the carrier uses the matrix below to determine the number of days from receipt to completion of hearings. The date of receipt in all cases is the day the carrier who is processing the case received it in its corporate mailroom. In out-of-area cases the receipt date is the date that the second carrier received the request.

Situation	Date Completed
An OTR decision is made and the appellant accepts the decision or decides to go directly to an ALJ hearing.	The date of the OTR decision.
An OTR decision is made, and the appellant chooses in a timely fashion, to proceed with the in-person or telephone hearing.	The date of the second decision. If the appellant does not appear, and the carrier dismisses the hearing, it uses the date of the dismissal notice.
An in-person or telephone hearing is held without an OTR decision.	The date of the decision.
The appellant withdraws the hearing request.	The date the carrier was notified of the withdrawal.
The HO dismisses the hearing request.	The date of the dismissal notice.

Line 23. Hearing Processing Time - Average - The carrier reports the average number of days from the receipt of the hearing request to the date of completion. See methodology under line 13.

Line 24. Hearings Completed in 1-60 Days - The number of hearings that required 1-60 days to complete. If a case is cleared the same day it is received, the carrier considers it to require 1 day.

Line 25. Hearings Completed in 61-90 Days - The number of hearings that required 61-90 days to complete.

Line 26. Hearings Completed in 91-120 Days - The number of hearings that required 91-120 days to complete.

Line 27. Number Completed Over 120 Days - The number of cases that required 121 days or more to complete.

Line 28. Closing Pending-Hearings - The total number of hearings that have not been completed by the end of the reporting month.

Line 29. Hearings Pending 1-60 Days - The number of hearings included in line 28 that were pending 1-60 days, inclusive, at the end of the reporting month.

Line 30. Hearings Pending 61-90 Days - The number of hearings included in line 28 that were pending 61-90 days, inclusive, at the end of the reporting month.

Line 31. Hearings Pending 91-120 Days - The number of hearings included in line 28 that were pending 91-120 days, inclusive, at the end of the reporting month.

Line 32. Hearings Pending Over 120 Days - The number of hearings included in line 28 that were pending more than 120 days at the end of the reporting month.

HEARING RESULTS

Hearings fall into the following categories:

Column (1) On-the-Record with No Subsequent Hearings - This column represents hearings where:

- The appellant originally requested an OTR hearing.
- The appellant indicated that the appellant was satisfied with the OTR decision, or
- That the appellant wished to proceed with an ALJ hearing (if the amount in controversy is $500 or more). In addition, if the appellant requests an in-person or telephone hearing subsequent to an OTR decision, but the hearing is dismissed or withdrawn, it is included here and not in columns (2) or (3).

Column (2) All Telephone - This column represents hearings where the appellant requested and had a telephone hearing subsequent to an OTR hearing decision, or a telephone hearing was held without a prior OTR decision. The carrier counts all telephone hearings including those where the appellant did not follow-up timely to the OTR notice but later requested a telephone hearing.

Column (3) All In-Person - This column represents hearings where the appellant requested and had an in-person hearing subsequent to an OTR hearing decision, or an in-person hearing was held without a prior OTR decision. The carrier counts all in-person hearings including those where the appellant did not follow-up timely to the OTR notice but later requested an in-person hearing.

Column (4) Number in 120 Days - For the total cases included in line 35, columns 2 and 3, the carrier shows for lines 37-39 the numbers that were completed within 120 days of receipt. It uses the methodology shown for lines 23-27 to determine the completion date. Where an OTR decision is made and the appellant chooses to not follow-up timely and later requests either an in-person or telephone hearing, the carrier measures the completion time for this second reported hearing from the date of receipt of the original request to the date of the second decision. If the appellant does not appear, it dismisses the hearing, and uses the date of notice of dismissal as its date completed.

Line 33. Reversals - Under the appropriate columns, the carrier shows the number of OTR, telephone, and in-person hearings completed in the month in which at least part of the review determination was reversed; i.e. a change was made and some, or all, of the new determination was in favor of the appellant. (See line 11 for a definition of a reversal.)

Line 34. Affirmation - Under the appropriate columns, the carrier shows the number of OTR, telephone, and in-person hearings completed in the month in which the review determination was completely upheld; i.e., no change was made. (See line 9 for a definition of affirmation.)

Line 35. Total Decisions - The carrier enters the total number of hearing decisions completed during the month that resulted in a reversal or affirmation (exclude dismissals and withdrawals). This includes those hearings shown in lines 9 and 11.

Line 36. Number in 120 Days - For cases included in line 35, the carrier shows the number that were completed within 120 days of receipt. It uses the methodology shown in column (4) to determine the completion date.

Line 37. No Previous OTR Held - For cases included in line 35, columns (2) and (3), the carrier reports the number where it held the telephone or in-person hearing without first making an OTR decision (i.e., the OTR hearing was bypassed.) In column (4), it reports the number of cases included in either column (2) or (3) that were completed within 120 days.

Line 38. Previous OTR Counted - For cases included in line 35, columns (2) and (3), the carrier reports the number where it included the **OTR** count on a previous report.   In column (4), it reports the number of cases included in either column (2) or (3) that were completed within 120 days. Cases reported in line 38 are those where an OTR decision was made, and the appellant either accepted the OTR decision, did not respond timely in accordance with The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals, or decided to go directly from the OTR decision to an ALJ hearing. Then, subsequent to this OTR decision "acceptance," the appellant decided that they wanted a telephone or in-person hearing. **The carrier does not include these cases in line 6.**

Line 39. Previous OTR Not Counted - For cases included in line 35, columns (2) and (3), the carrier reports the number where it did not include the **OTR** count on a previous report. These are cases where it made the OTR decision first and the appellant indicated in a timely fashion that they wanted a telephone or in-person hearing. In column (4), it reports the number of cases included in either column (2) or (3) that were completed within 120 days.

360.3 - Section B - ALJ Hearings

(Rev. 6, 08-30-02)
B3-13410.3

Section B is intended for all requests for ALJ hearings including those expected to be dismissed for failure to meet the $500 amount in controversy requirement or for any other reason (such as a lack of a fair hearing).

The carrier counts ALJ Hearings in Columns 1 and 2 using the following two methodologies:

Column (1) Total - The total of all ALJ hearing requests as originally filed.

Column (2) Dispositions - For lines 49 and 51-53 only, the carrier enters the number of dispositions rendered by the ALJ(s) in cases reported as cleared for the month in Line 49. There will usually be more ALJ dispositions than cases counted in line 49. A case is not counted in line 49 until the ALJ has cleared **all of the claims** included in the request for hearing.

EXAMPLE: The carrier forwards one request to an ALJ involving 20 claims. The ALJ dismisses 10 claims at once. A month later, the ALJ decides to affirm the original decision on 5 others as one group. The other 5 receive separate determinations. This is counted as 7 dispositions.

Line 40. Opening Pending - The number of ALJ hearings reported on line 57 as closing pending on the previous month's report.

Line 41. Adjustments to Pending - If line 42 of the current month differs from data in line 57 of the previous month, there must be an entry in line 41 for the current month. The carrier precedes the entry by a "+" or "-", as appropriate. See definition for line 2.

Line 42. Adjusted Opening Pending - The result of line 40 + line 41 (taking into account the "-" sign, if any).

Line 43. Requests Received - The number of ALJ hearings requested during the month. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals.)

Line 44. Requests Forwarded to ALJ - The number of ALJ hearing requests forwarded to ALJs during the month. The carrier considers the case forwarded when all necessary material has been mailed to the ALJ.

Line 45. No. of Claims Involved - The number of claims involved in the ALJ hearing requests forwarded to ALJs as reported on line 44. (See MCM-3, §§3000-3000.2 for definition of claim.)

Line 46. **No. Forwarded in 1-7 Days** - The number of ALJ hearing requests forwarded to ALJs within 7 calendar days from receipt of the request to mailing of the necessary information. The carrier shows data for all cases mailed during the month. The number must be less than, or equal to, the number shown in line 44.

Line 47. No. Forwarded in 1-14 Days - The number of ALJ hearing requests forwarded to ALJs within 14 days from receipt of the request to mailing of the necessary information. The carrier shows data for all cases mailed during the month. The number must be less than, or equal to, the number shown in line 44.

Line 48. Average Time to Forward - The average number of calendar days from receipt of the ALJ request to the mailing date of the necessary information. The carrier the same methodology for counting as discussed in §360.2 for line 13.

Line 49. ALJ Hearings Completed - The number of ALJ hearing requests completed during the month. The carrier considers a case completed when it receives the completed decision from the ALJ for all parts of the case.

Line 50. Amount in Controversy - For ALJ hearings reported as affirmed (line 51) or reversed (line 53), during the month, the carrier shows the total dollar amount remaining in controversy according to the initial ALJ hearing request. This should be the amount remaining after previous appeal decisions. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals on how to determine the amount in controversy.) **It rounds results to the nearest dollar.**

Line 51. Affirmations - The carrier enters number of completed ALJ hearings in which the previous determination was completely upheld i.e., no change was made. All parts of all claims in a case must be upheld in order for the case to be counted as an affirmation. See line 53 for partial affirmations. (The carrier does not include partial affirmations on this line.)

If the prior determination is upheld, but payment is made under limitation of liability, the carrier counts the ALJ hearing determination as an affirmation. It reports the appropriate information in lines 55 and 56.

Line 52. **Dismissals/Withdrawals** - The e number of completed ALJ hearings that were withdrawn by the appellant or dismissed (before determination) by the ALJ. The carrier reports an appeal that was requested and withdrawn or dismissed within the same month here and in lines 43, 44, and 49.

Line 53. **Reversals (Full or Part)** - The total number of completed ALJ hearings in which at least part of the prior determination was reversed i.e., a change was made and some or all of the new determination was in favor of the appellant. For example, if an ALJ hearing involves several claims, and the initial determinations for some of the claims are affirmed and some are reversed, the carrier considers the decision a reversal.

Line 54. **Amount Awarded** - For cases included in line 53, the carrier shows the amount of allowed charges for services where the determination was reversed. It shows charges after reasonable charge reductions, but prior to application of deductible and coinsurance amounts. (If the appeal involved a reasonable charge reduction, it shows the additional amount allowed.) It rounds results to the nearest dollar.

Line 55. Waived - Ben. and Prov - The number of claims involved in requests for ALJ hearings where limitation of liability was granted to both the beneficiary and provider in an assigned claim (see The Medicare Claims Processing Manual, Chapter X, Limitation on Liability), or where the provider's liability was limited in an unassigned claim(see 3 The Medicare Claims Processing Manual, Chapter X, Limitation on Liability).

Line 56. Amount Awarded - For cases included in line 55, the carrier shows the amount of allowed charges for services (including the noncovered services) where the liability of the beneficiary and provider were limited. It shows charges after reasonable charge reductions, but prior to application of deductible and coinsurance amounts, rounding results to the nearest dollar.

Line 57. Closing Pending - The total number of ALJ hearing requests that were not completed by the end of the reporting month. The carrier considers a case transferred to an ALJ as pending until it has received the complete decision from the ALJ for all parts of the case.

Line 58. Effectuation of ALJ Decisions - The number of ALJ hearing decisions for which it initiated effectuation during the month. The carrier considers effectuation of a decision to be initiated when it completes the following:

- Submission of claim to CWF if payment can be made without further development; or

- Initiation of development e.g., when it must ascertain whether or not the provider has refunded payment to the beneficiary.

Line 59. Number 1-7 Days - The number of cases where the carrier effectuated the decision within 7 days, inclusive, of receipt of the decision in its corporate mailroom.

Line 60. Number 8-15 Days - The number of cases where the carrier effectuated the decision within 8-15 days, inclusive, of receipt of the decision in its corporate mailroom.

Line 61. Number 16-30 Days - The number of cases where the carrier effectuated the decision within 16-30 days, inclusive, of receipt of the decision in its corporate mailroom.

Line 62. Number Over 30 Days - The number of cases where the carrier effectuated the decision in more than 30 days, inclusive, of receipt of the decision in its corporate mailroom.

360.4 - Section C - Reopenings (Claim Counts)

(Rev. 6, 08-30-02)
B3-13410.4

The carrier reports the number of claims (as defined in §§3000-3000.2) involved in reopenings completed during the month. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals) for discussion of what constitutes a reopening.) Claims review, hearings, and ALJ hearings undertaken as part of the appeal process are not considered reopenings.

Reopenings fall into the following categories:

Column (1) Total - The number of reopenings completed.

Column (2) Pre-Review - The number of reopenings of initial claim determinations. If a claim has been through a review or any type of hearing, the carrier does not count it here.

Column (3) Post-Review - The number of reopenings of review determinations. If a claim has been through any type of hearing, the carrier does not count it here.

Column (4) Post-Hearing - The number of reopenings of hearing determinations regardless of the type of hearing e.g., carrier HO or ALJ. Once a claim has been through a carrier hearing, it is counted here if it is reopened.

Line 63. Total - The number of claims for which the carrier completed the reopening of a claim determination, review determination, or hearing determination, whether or not the determination was revised.

Line 64. Unfavorable to Claimant - Of the claims shown in line 63, this is a count of those that resulted in an unfavorable revision of a previously favorable decision.

Line 65. No Change - Of the claims shown in line 63, these are those that the carrier reopened but did not revise the initial determination.

Line 66. Favorable to Claimant - Of the claims shown in line 63, these are those that resulted in a favorable revision of a previously unfavorable decision.

Line 67. Amount Awarded - For cases included in line 66, the carrier shows the amount of allowed charges for services that involved a revision of a previously unfavorable decision. It shows charges after reasonable charge reductions but prior to application of the deductible and coinsurance amounts. (If the reopening involved a reasonable charge reduction, it shows the additional amount allowed.) It rounds results to the nearest dollar.

360.5 - Section D - Limitation of Liability (Claim Counts)

(Rev. 6, 08-30-02)
B3-13410.5

ASSIGNED CASES

To include an assigned claim in lines 68-71, the carrier must have originally denied it or reduced it as "not reasonable and necessary" under §1862(a)(1) of the Act. (see The Medicare Claims Processing Manual, Chapter X, Limitation on Liability)

Lines 69-71 are mutually exclusive i.e., a claim meeting the above condition may be counted on only one of the three lines. Therefore, the carrier ensures that the sum of the number of claims recorded on each of these lines equals the total number of assigned claims considered for limitation of liability during the period reported on line 68.

The counts in lines 69-71 reflect counts of **claims** at the initial claim (column 1), review (column 2), and hearing levels (column 3) (as defined in MCM-3, §§3000-3000.2), not review or hearing requests. The carrier reports cases corresponding to the claims counted here in Section A also, as appropriate. If a claim is considered for limitation of liability at the initial claim level, the carrier does not count it at the or hearing level unless it changes the limitation of liability decision.

It categorizes claims for columns shown in Section D according to the adjudication level at which limitation of liability is considered or granted. If it makes several different limitation of liability decisions on the same claim, it uses the highest numbered line on the report that applies to that claim. It counts the claim only once. For instance, if it waives liability for both the beneficiary and provider liability on any part of the claim, it counts the claim only on line 71.

Line 68. Total Number Considered - The carrier enters, under the appropriate columns, the number of assigned claims meeting the conditions above for which limitation of liability was considered during the month.

Line 69. Considered - Not Waived - The carrier enters under the appropriate columns the number of assigned claims meeting the conditions above on which limitation of liability was considered but was not granted to the beneficiary.

Line 70. Waived - Bene. Only - The carrier shows, under the appropriate columns, the number of assigned claims meeting the conditions above on which it granted limitation of liability to only the beneficiary.
Line 71. Waived - Bene. and Prov. - The carrier enters, under the appropriate columns, the numbers of assigned claims where it granted limitation of liability during the reporting month to both the beneficiary and provider.

Line 72. Amount Awarded - For cases included in line 71, the carrier shows the amount of allowed charges for services (including noncovered services) where limitation of liability is granted to the beneficiary and provider. It shows charges after reasonable charge reductions, but prior to application of deductible and coinsurance amounts, rounding results to the nearest dollar.

UNASSIGNED CASES

This section applies to claims where waiver of a provider's liability to make refund to the beneficiary on unassigned claims for those services found to be not reasonable or necessary is considered under “Limitation on Liability”. See The Medicare Claims Processing Manual, Chapter X, Limitation on Liability.

Line 73. Total Number Considered - The carrier enters, under the appropriate columns, the number of unassigned claims that meet the conditions of §7330 for which limitation of liability was considered during the month.

Line 74. Phys. Refund Waived - The carrier enters, under the appropriate columns, the number of unassigned claims that meet the requirements of §7330 on which it waived the liability of the provider to refund to the beneficiary the amount disallowed as not reasonable and necessary.

Line 75. Phys. Refund Upheld - The carrier enters, under the appropriate columns, the number of unassigned claims that meet the requirements of The Medicare Claims Processing Manual, Chapter X, Limitation on Liability chapter, on which it required the physician to refund the amount disallowed.

370 - Checking Reports

(Rev. 6, 08-30-02)
B3-13415

Before sending the report to CMS, the carrier checks for completeness and arithmetical accuracy. It uses the following checklist for each column:

- Line 1 column (1) must be equal to line 18 of previous month.
- Line 1 column (3) must be equal to line 28 of previous month.
- Line 1 + line 2 = line 3 for columns (1) and (3).
- Line 3 column (1) + line 4 column (1) - line 5 column (1) - line 6 column (1) = line 18.
- Line 3 column (3) + line 4 column (3) - line 5 column (3) - line 6 column (3) = line 28.
- Line 4A must be less than or equal to line 4 for columns (1) and (3).
- Line 6 = line 9 + line 10 + line 11.
- Line 9 column (3) + line 11 column (3) must be less than or equal to line 35 (sum of all columns).
- Line 6 column (1) = line 14 + line 15 + line 16 + line 17.
- Line 6 column (3) = line 24 + line 25 + line 26 + line 27.
- Column (2) must be less than or equal to column (1) for lines 6, 7, 9, 10, 11, and 12.
- Line 7 must be greater than or equal to line 6.
- Line 18 = line 19 + line 20 + line 21 + line 22.
- Line 28 = line 29 + line 30 + line 31 + line 32.
- Line 35 = line 33 + line 34.
- Line 35 = line 37 + line 38 + line 39 for columns 2 and 3 only.

- Line 36 must be less than or equal to line 35 for columns 1, 2, and 3.
- Line 37 (column 4) must be less than or equal to line 37 (column 2) + line 37 (column 3).
- Line 38 (column 4) must be less than or equal to line 38 (column 2) + line 38 (column 3).
- Line 39 (column 4) must be less than or equal to line 39 (column 2) + line 39 (column 3).
- Line 40 must be equal to line 57 of the previous month for column 1 only.
- Line 42 = line 40 + line 41 for column 1.
- Line 42 + line 43 - line 49 = line 57 for column 1 only.
- Line 45 must be greater than or equal to line 44 for column 1 only.
- Line 46 must be less than or equal to line 44 for column 1 only.
- Line 47 must be less than or equal to line 44 for column 1 only.
- Line 49 = line 51 + line 52 + line 53.
- Line 50 must be greater than or equal to 500 times the sum of lines 51 and 53 for column 1 only (each case must involve at least $500).
- Column 2 must be greater than or equal to column 1 for lines 49 and 51 - 53.
- Line 54 must be greater than or equal to line 53 for column 1 only (must award at least $1 per case).
- Line 56 must be greater than or equal to line 55 for column 1 only (at least $1 per case).
- Line 58 = line 59 + line 60 + line 61 + line 62.
- Line 63 = line 64 + line 65 + line 66.
- Line 67 must be greater than or equal to line 66 (at least $1 per case).
- Line 68 = line 69 + line 70 + line 71.
- Line 72 must be greater than or equal to line 71 (at least $1 per case).
- Line 73 must be greater than or equal to line 74.
- Line 73 must be greater than or equal to line 75.
- Column 1 = column 2 + column 3 + column 4 for lines 63 - 67.

Public reporting burden for this collection of information is estimated to average 2 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden may be sent to the following:

Centers for Medicare & Medicaid Services
Office of Financial Management
P.O. Box 26684
Baltimore, MD 21207

and to the

Office of Management and Budget
Paperwork Reduction Project (0938-0452)
Washington, DC 20503.

380 - Exhibits

(Rev. 6, 08-30-02)
B3-13416

Exhibit 1 - Medicare Program - Carrier Appeal Report - Form CMS-2590

MEDICARE PROGRAM - CARRIER APPEAL REPORT - FORM CMS-2590

CARRIER ID ____________________ REPORT PERIOD ______________________

A. CARRIER APPEAL REQUESTS	TOTAL REVIEWS (1)	TELEPHONE REVIEWS (2)	HEARINGS (3)
1. OPENING PENDING			
2. ADJSTMTS TO PNDNG			
3. ADJUSTED PENDING			
4. REQUESTS RECEIVED			
4A. MED. DOC. DENIALS			
5. REQUESTS TRANSFERRED			
6. REQUESTS CLEARED			
7. NO. OF CLAIMS			
8. AMT IN CONTROVERSY			
9. AFFIRMATIONS			
10. DISMISSED/WITHDRAWN			
11. REVERSALS			
12. AMOUNT AWARDED			

FORM CMS-2590 SCREEN 1

Exhibit 2 - Medicare Program - Carrier Appeals Report - Form CMS-2590

MEDICARE PROGRAM - CARRIER APPEALS REPORT - FORM CMS-2590

CARRIER ID ___________________ REPORT PERIOD ______________________

REVIEW REQUESTS	REVIEWS (1)	HEARING REQUESTS	HEARINGS (2)
PROCESSING TIMES		PROCESSING TIMES	
13. REVIEWS- AVERAGE		23. HEARINGS- AVERAGE	
14. NBR COMP 1-30 DYS		24. NBR COMP 1-60 DYS	
15. NBR COMP 31-45 DYS		25. NBR COMP 61-90 DYS	
16. NBR COMP 46-60 DYS		26. NBR COMP 91-120 DYS	
17. NBR COMP 60 DYS+		27. NBR COMP 120 DYS+	
PENDING TIMES		PENDING TIMES	
18. CLOSING PENDING		28. CLOSING PENDING	
19. NBR COMP 1-30 DYS		29. NBR COMP 1-60 DYS	
20. NBR COMP 31-45 DYS		30. NBR COMP 61-90 DYS	
21. NBR COMP 46-60 DYS		31. NBR COMP 91-120 DYS	
22. NBR COMP 60 DYS+		32. NBR COMP 120 DYS+	

HEARING RESULTS	OTR WITH NO SUBSEQUENT HEARING (1)	TELEPHONE (2)	IN-PERSON (3)	NBR IN 120 DYS (4)
33. REVERSALS				
34. AFFIRMATIONS				
35. TOTAL DECISIONS				
36. NBR IN 120 DYS				
37. NO PREV OTR HELD				
38. PREV OTR COUNTED				
39. PREV OTR NOT COUNTED				

FORM CMS-2590 SCREEN 2

Exhibit 3 - Medicare Program - Carrier Appeals Report - Form CMS 2590

MEDICARE PROGRAM - CARRIER APPEALS REPORT - FORM CMS 2590

CARRIER ID ____________________ REPORT PERIOD ______________________

B. PART B ALJ HEARINGS	**TOTAL (1)**	**DISPOSITIONS (2)**	B. PART B ALJ HEARINGS	TOTAL (1)
40 OPENING PENDING			55. WAIVED - BEN & PROV	
41 ADJUSTMENTS TO PENDING			56. AMOUNT AWARDED	
42. ADJUSTED OPENING PENDING			57. CLOSING PENDING	
43. REQUESTS RECEIVED			58. EFFECT. OF ALJ DEC	
44. REQ. FORWARDED TO ALJ			59. NO. 1-7 DAYS	
45. NO. OF CLAIMS INVOLVED			60. NO. 8-15 DAYS	
46. NO. IN 1-7 CALNDR DAYS			61. NO. 16-30 DAYS	
47. NO. IN 1-14 CLNDR DAYS			62. NO. OVER 30 DAYS	
48. AVG TIME TO FORWARD				
49. COMPLETED				
50. AMOUNT IN CONTROVERSY				
51. AFFIRMATIONS				
52. DISMISSALS/WITHDRAWALS				
53. REVERSALS (FULL/PART)				
54. AMOUNT AWARDED				

FORM CMS-2590 SCREEN 3

Exhibit 4 - Medicare Program - Carrier Appeals Report - Form CMS-2590

MEDICARE PROGRAM - CARRIER APPEALS REPORT - FORM CMS-2590

CARRIER ID ____________________ REPORT PERIOD _____________________

C. REOPENINGS (CLAIM COUNTS	TOTAL (1)	PRE-REVIEW (2)	POST-REVIEW (3)	POST-HEARING (4)
63. TOTAL				
64. UNFAVORABLE TO CLAIMANT				
65. NO CHANGE				
66. FAVORABLE TO CLAIMANT				
67. AMOUNT AWARDED				

D. LIMITATION OF LIABILITY (CLAIM COUNTS)	INITIAL CLAIM (1)	REVIEW (2)	HEARING (3)	
ASSIGNED CASES				
68. TOTAL NUMBER CONSIDERED				
69. CONSIDERED - NOT WAIVED				
70. WAIVED-BEN. ONLY				
71. WAIVED-BEN.& PROV				
72. AMT AWARDED				
UNASSIGNED CASES				
73. TOTAL NUMBER CONSIDERED				
74. PHYS REFUND WAIVED				
75. PHYS REFUND UPHELD				

FORM CMS-2590 SCREEN 4

390 - Participating Physician/Supplier Report
(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

Unless otherwise requested, the carrier*/A/B MAC* prepares and transmits to CMS each year a report updating the number and category of participating physicians and suppliers. It completes a separate report for each office assigned a separate carrier number.

390.1 - Purpose and Scope
(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

This report enables CMS to gather data for administrative purposes on the number of physicians, *limited license physicians*, non-physician practitioners and suppliers, by specialty code, electing to participate in CMS' Participating Physician/Supplier Program.

390.2 - Due Date
(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

The carrier*/A/B MAC* transmits data about the Participating Physician/Supplier Program to CO via PC or terminal. It uses instructions in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.

The report is due 45 days after the end of the enrollment period. It includes updated data as of the end of the most recent enrollment period.

The carrier*/A/B MAC* does not submit hard copies of the report.

400 - Completion of Items on Participating Physician/Supplier Report
(Rev. 6, 08-30-02)
B3-13422

400.1 - Heading
(Rev. 6, 08-30-02)
B3-13422.1

This report is referenced as Form F in the CROWD system. The carrier completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

400.2 - Definitions of Columns One Through Eight
(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Column 1 - Participating Physicians/LLPs/NPPs/Suppliers - Prior - A count of the number of physicians, limited license physicians (LLPs), non-physician practitioners (NPPs), and suppliers participating prior to the beginning of the latest enrollment period.

> **Note:** The carrier or A/B MAC adjusts this data if there are changes from the information submitted in column 2 on the previous enrollment period.

Examples of possible reasons for changes to the data include:

- Addition of new physicians to the Medicare file;
- Reclassification of physicians, LLPs, NPPs, and suppliers between specialty designations;
- Deletion of deceased or retired physicians from the Medicare file; or
- Technical corrections to previously submitted data.

Column 2 - Participating Physicians/LLPs/NPPs/Suppliers - Current - The number of physicians, limited license physicians, NPPs, and suppliers who are continuing as participants from the prior participation period into the new participation period and the number who have **newly** signed participation agreements in the latest enrollment period.

Column 3 - Participating Physicians/LLPs/NPPs/Suppliers - Continuing - Only the number of physicians, limited license physicians, NPPs, and suppliers **continuing** as participants from the prior participation period into the new participation period, not including those who have newly signed participation agreements in the latest enrollment period or those who have dropped out.

Column 4 - Non-Participating Physicians/LLPs/NPPs/Suppliers - Prior - A count of physicians, limited license physicians, NPPs, and suppliers not participating at the beginning of the latest enrollment period.

> **Note:** The carrier or A/B MAC adjusts this data if the information is different from that submitted in column 5 on the previous enrollment period. (See column 1 for further information.)

Column 5 - Non-Participating Physicians/LLPs/NPPs/Suppliers - Current - A count of physicians, limited license physicians, NPPs, and suppliers not participating after the latest enrollment period, including those who were not participating at the beginning of the latest enrollment period and chose not to enroll and those who disenrolled during the latest period.

Column 6 - Participating Drop-Out - Current – Physicians/LLPs/NPPs, and suppliers who, prior to this enrollment period, were participating in the program and have now decided to drop out.

Column 7 - Non-Participating Sign-Up - Current – Physicians/LLPs/NPPs, and suppliers who were non-participating prior to the latest enrollment period and who enrolled in the program during the latest enrollment period.

Column 8 – Participating Disenrolls - Only the number of participants who disenrolled from the Medicare program during an authorized disenrollment period held during the past 12 months. This is blank unless CMS declares an authorized disenrollment period.

400.3 - Specialty Codes

(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

The contractor counts individual participants by specialty. It does not count an individual more than once, even if the individual practices in more than one setting.

NOTE: Refer to the pre-April 2010 version for DMERC activity (Calendar Years 1993-2007)

400.4 - Physician/Limited License Physician Specialty Codes

(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

The following list of codes and narrative describe the kind of medicine physicians practice.

Code	***Physician/Limited License Physician (LLP) Specialty Codes***
01	*General Practice*
02	*General Surgery*
03	*Allergy/Immunology*
04	*Otolaryngology*
05	*Anesthesiology*
06	*Cardiology*
07	*Dermatology*
08	*Family Practice*
09	*Interventional Pain Management*
10	*Gastroenterology*
11	*Internal Medicine*
12	*Osteopathic Manipulative Medicine*
13	*Neurology*
14	*Neurosurgery*
16	*Obstetrics/Gynecology*
17	*Hospice and Palliative Care*
18	*Ophthalmology*
19	*Oral Surgery (Dentists only) (LLP)*
20	*Orthopedic Surgery*
21	*Cardiac Electrophysiology*
22	*Pathology*
23	*Sports Medicine*
24	*Plastic and Reconstructive Surgery*
25	*Physical Medicine and Rehabilitation*
26	*Psychiatry*
27	*Geriatric Psychiatry*
28	*Colorectal Surgery (formerly Proctology)*
29	*Pulmonary Disease*
30	*Diagnostic Radiology*
33	*Thoracic Surgery*
34	*Urology*
35	*Chiropractic (LLP)*
36	*Nuclear Medicine*
37	*Pediatric Medicine*
38	*Geriatric Medicine*
39	*Nephrology*
40	*Hand Surgery*
41	*Optometry (LLP)*
44	*Infectious Disease*

Code	Physician/Limited License Physician (LLP) Specialty Codes
46	Endocrinology
48	Podiatry (LLP)
66	Rheumatology
70	Single or Multispecialty Clinic or Group Practice
72	Pain Management
73	Mass Immunization Roster Biller
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivist)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery (LLP)
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty

Note: Specialty Code Use for Service in an Independent Laboratory*. For services performed in an independent laboratory, show the specialty code of the physician ordering the x-rays and requesting payment. If the independent laboratory requests payment, use supplier code "69".*

400.5 - Non-Physician Practitioner/Supplier Specialty Codes
(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

The following list of codes and narrative describe the kind of medicine non-physician practitioners or other healthcare providers/suppliers practice.

Code	***Non-Physician Practitioner/Supplier Specialty Codes***
15	*Speech Language Pathologists*
31	*Intensive Cardiac Rehabilitation (ICR)*
32	*Anesthesiologist Assistant*
42	*Certified Nurse Midwife (effective July 1, 1988)*
43	*Certified Registered Nurse Anesthetist (CRNA)*
45	*Mammography Screening Center*
47	*Independent Diagnostic Testing Facility (IDTF)*
49	*Ambulatory Surgical Center*
50	*Nurse Practitioner*
59	*Ambulance Service Supplier, e.g., private ambulance companies, funeral homes*
60	*Public Health or Welfare Agencies (Federal, State, and local)*
61	*Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)*
62	*Clinical Psychologist (Billing Independently)*
63	*Portable X-Ray Supplier (Billing Independently)*
64	*Audiologist (Billing Independently)*
65	*Physical Therapist in Private Practice*
67	*Occupational Therapist in Private Practice*
68	*Clinical Psychologist*
69	*Clinical Laboratory (Billing Independently)*
71	*Registered Dietician/Nutrition Professional*
73	*Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)*
74	*Radiation Therapy Centers*
75	*Slide Preparation Facilities*
80	*Licensed Clinical Social Worker*
88	*Unknown Supplier/Provider*
89	*Certified Clinical Nurse Specialist*
97	*Physician Assistant*

NOTE: Specialty Code Use for Service in an Independent Laboratory*. For services performed in an independent laboratory, show the specialty code of the physician ordering the x-rays and requesting payment. If the independent laboratory requests payment, use supplier code "69".*

410 - Checking Reports
(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

Before submitting Form F, the carrier*/A/B MAC* checks for completeness and arithmetical accuracy using the following checklist:

- Column 3 must be = to or < column 1
- Column 3 must be = to or < column 2
- Column 6 = column 1 - column 3
- Column 7 = column 2 - column 3
- Total Physicians = sum of Group PHY for all columns.
- Total LLPs = sum of Group LLP for all columns.
- Total NPPs = sum of Group NPP for all columns.
- Total Suppliers = sum of Group SUP for all columns.

420 - Exhibit

(Rev. 191, Issued: 07-13-11, Effective, 07-01-11, Implementation: 07-05-11)

Exhibit 1 - Participating Physician/Supplier Report - Screen 1

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

01 General Practice
02 General Surgery
03 Allergy/Immunology
04 Otolaryngology
05 Anesthesiology
06 Cardiology
07 Dermatology
08 Family Practice
09 Interventional Pain Management
10 Gastroenterology
11 Internal Medicine

	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
SPECIALTY CODE/GROUP	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
01-PHY								
02-PHY								
03-PHY								
04-PHY								
05-PHY								
06-PHY								
07-PHY								
08-PHY								
09-PHY								
10-PHY								
11-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 2

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

12 Osteopathic Manipulative Medicine
13 Neurology
14 Neurosurgery
15 Speech Language Pathologist
16 Obstetrics/Gynecology
17 Hospice and Palliative Care
18 Ophthalmology
19 Oral Surgery
20 Orthopedic Surgery
21 *Cardiac Electrophysiology*
22 Pathology
23 *Sports Medicine*
24 Plastic and Reconstructive Surgery

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
12-PHY								
13-PHY								
14-PHY								
15-NPP								
16-PHY								
17-PHY								
18-PHY								
19-PHY								
20-PHY								
21-*PHY*								
22-PHY								
23-*PHY*								
24-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 3

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

25 Physical Medicine and Rehabilitation
26 Psychiatry
27 Geriatric Psychiatry
28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease
30 Diagnostic Radiology
31 Intensive Cardiac Rehabilitation (ICR)
32 Anesthesiologist Assistant
33 Thoracic Surgery
34 Urology
35 Chiropractic
36 Nuclear Medicine
37 Pediatric Medicine

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
25-PHY								
26-PHY								
27-PHY								
28-PHY								
29-PHY								
30-PHY								
31-SUP								
32-NPP								
33-PHY								
34-PHY								
35-PHY								
36-PHY								
37-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 4

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

38 Geriatric Medicine
39 Nephrology
40 Hand Surgery
41 Optometry
42 Certified Nurse Midwife
43 Certified Registered Nurse Anesthetist (CRNA)
44 Infectious Disease
45 Mammography Screening Center
46 Endocrinology
47 Independent Diagnostic Testing Facility (DTL)
48 Podiatry
49 Ambulatory Surgical Center
50 Nurse Practitioner

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
38-PHY								
39-PHY								
40-PHY								
41-PHY								
42-NPP								
43-NPP								
44-PHY								
45-SUP								
46-PHY								
47-SUP								
48-PHY								
49-SUP								
50-NPP								

Exhibit 1 - Participating Physician/Supplier Report - Screen 5

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

59 Ambulance Service Supplier
60 Public Health/Welfare Agency
61 Volunteer Health/Charitable Agency
62 Clinical Psychologist (Ind.)
63 Portable X-Ray Supplier
64 Audiologist (Ind.)
65 Physical Therapist (Ind.)
66 Rheumatology
67 Occupational Therapist (Ind.)
68 Clinical Psychologist
69 Clinical Laboratory (Ind.)
70 Single or Multi-Specialty Clinic or Group Practice
71 Registered Dietitian/Nutrition Professional

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
59-SUP								
60-SUP								
61-SUP								
62-NPP								
63-SUP								
64-NPP								
65-NPP								
66-PHY								
67-NPP								
68-NPP								
69-SUP								
70-PHY								
71-NPP								

Exhibit 1 - Participating Physician/Supplier Report - Screen 6

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

72 Pain Management
73 Mass Immunization Roster Biller
74 Radiation Therapy Centers
75 Slide Preparation Facilities
76 Peripheral Vascular Disease
77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
80 Licensed Clinical Social Worker
81 Critical Care (Intensivist)
82 Hematology
83 Hematology/Oncology
84 Preventative Medicine

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
72-PHY								
73-SUP								
74-SUP								
75-SUP								
76-PHY								
77-PHY								
78-PHY								
79-PHY								
80-NPP								
81-PHY								
82-PHY								
83-PHY								
84-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 7

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

85 Maxillofacial Surgery
86 Neuropsychiatry
88 Unknown Supplier/Provider
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
95 Reserved
97 Physician Assistant
98 Gynecological Oncology
99 Unknown Physician Specialty

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin. (3)	Prior (4)	Current (5)			
85-PHY								
86-PHY								
88-SUP								
89-NPP								
90-PHY								
91-PHY								
92-PHY								
93-PHY								
94-PHY								
95-RES								
97-NPP								
98-PHY								
99-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 8

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

Total Physicians - The contractor enters in the appropriate column the total of all specialty codes applicable to physicians.

Total LLPs - The contractor enters in the appropriate column the total of all specialty codes applicable to limited license physicians.

Total NPPs - The contractor enters in the appropriate column the total of all specialty codes applicable to non-physician practitioners.

Total Physicians/LLPs/NPPs - The contractor enters in the appropriate column the sum of all physicians, LLPs and NPPs.

Total Suppliers - The contractor enters in the appropriate column the total of all specialty codes applicable to suppliers.

SPECIALTY CODE/GROUP	Participants			Non-Participants		Par Drop-Out Current (6)	Non-Par Sign-Up Current (7)	Par Disenrolls (8)
	Prior (1)	Current (2)	Contin (3)	Prior (4)	Current (5)			
TOTALs								
PHYs*								
LLPs*								
NPPs*								
PHYs/LLPS/NPPs *								
SUPs*								

* These lines do not represent specific specialty codes. They are the totals of the specialty sub-groups.

430 - Completing Quarterly Report On Provider Enrollment (Inactive)
(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Each quarter, the carrier prepares and submits to CMS a report on the number of provider enrollment applications received, processed, and pending during the quarter. It submits this report via the Contractor Reporting of Operational and Workload Data (CROWD) system no later than the fifteenth day following the close of the reporting quarter.

430.1 - Heading
(Rev. 6, 08-30-02)
B3-13430.1

This report is referenced as Form 4 in the CROWD system. The carrier completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

430.2 - Checking Reports
(Rev. 6, 08-30-02)
B3-13430.2

Before submitting Form 4 to CMS, the carrier checks for completeness and arithmetical accuracy, using the following checklist:

- For all lines, column 1 must equal the sum of columns 2-24.
- For all columns, line 1 must equal line 11 from the previous quarter.
- For all columns, line 3 must equal line 1 plus line 2.
- For all columns, line 6 must equal line 4 plus line 5.
- For all columns, line 10 must equal the sum of lines 7-9.
- For all columns, line 11 must equal line 3 plus line 6 minus line 10.
- For all columns, the sum of lines 12-17 must equal line 8.
- For all columns, the sum of lines 18-22 must equal line 9.
- For all columns, the sum of lines 23-26 must equal line 10.
- For all columns, line 27 must equal line 34 from the previous quarter.
- For all columns, line 29 must equal line 27 plus line 28.
- For all columns, line 33 must equal line 31 plus line 32.
- For all columns, line 34 must equal line 29 plus line 30 minus line 33.

430.3 - Type of Provider
(Rev. 6, 08-30-02)
B3-13430.3

The carrier reports provider enrollment application data in the following columns for all lines on Form 4.

Column (1) - Total - The sum of columns 2-24 for each line.

Column (2) - Physician - Provider applications for specialty codes 1-8, 10-14, 16, 18-20, 22, 24-26, 28-30, 33-41, 44, 46, 48, 66, 76-79, 81-86, 90-94, 98, and 99.

Column (3) - Group - Provider applications for specialty code 70.

Column (4) - Certified Nurse Midwife - Provider applications for specialty code 42.

Column (5) - Certified Registered Nurse Anesthetist - Provider applications for specialty code 43.

Column (6) - Nurse Practitioner - Provider applications for specialty code 50.

Column (7) - Ambulance Service Supplier - Provider applications for specialty code 59.

Column (8) - Independent Audiologist - Provider applications for specialty code 64.

Column (9) - Independent Physical Therapist - Provider applications for specialty code 65.

Column (10) - Independent Occupational Therapist - Provider applications for specialty code 67.

Column (11) - Clinical Psychologist - Provider applications for specialty code 68.

Column (12) - Licensed Clinical Social Worker - Provider applications for specialty code 80.

Column (13) - Certified Nurse Specialist - Provider applications for specialty code 89.

Column (14) - Independent Physiological Laboratory - Provider applications for specialty code 95.

Column (15) - Physician Assistant - Provider applications for specialty code 97.

Column (16) - Mammography Screening Center - Provider applications for specialty code 45.

Column (17 - Ambulatory Surgical Center - Provider applications for specialty code 49.

Column (18) - Public Health/Welfare Agency - Provider applications for specialty code 60.

Column (19) - Voluntary Health/Charitable Agency - Provider applications for specialty code 61.

Column (20) - Independent Psychologist - Provider applications for specialty code 62.

Column (21) - Portable X-Ray - Provider applications for specialty code 63.

Column (22) - Independent Clinical Laboratory - Provider applications for specialty code 69.

Column (23) - Unknown Supplier/Provider - Provider applications for specialty code 88.

Column (24) - Flu Immunization Biller - Providers applications from individuals identified as flu immunization billers.

430.4 - Completing Lines One Through Eleven - Workload Operations
(Rev. 6, 08-30-02)
B3-13430.4

Line 1 - Pending End of Last Quarter - The CROWD system will automatically enter the value from line 11 on the previous quarter's report.

Line 2 - Adjustments to Pending - If it is necessary to revise the pending figure for the close of the previous quarter because of inventories taken or reporting errors discovered, the carrier enters the adjustment here. Adjustments can be positive or negative values. If entering a negative value, it precedes the number with a minus (-) sign.

Line 3 - Adjusted Opening Pending - The CROWD system will automatically sum the values on lines 1and 2.

Line 4 - New Applications Received - The number of applications received for the first time during the reporting quarter.

Line 5 - Returned Applications Resubmitted - The number of applications received during the reporting quarter that had previously been received and returned to the applicant for correction/completion.

Line 6 - Total Applications Received - The CROWD system will automatically sum the values on lines 4 and 5.

Line 7 - Applications Approved - The number of applications approved (i.e., Medicare number issued) during the reporting quarter.

Line 8 - Applications Denied - The number of applications denied during the reporting quarter.

Line 9 - Applications Returned - The number of applications returned to the applicant for corrections/completion during the reporting quarter.

Line 10 - Total Applications Processed - The CROWD system will automatically sum the values on lines 7, 8, and 9.

Line 11 - Pending End of Quarter - The CROWD system will automatically compute the number of applications pending at the end of the reporting quarter by adding the value on line 3 to the value on line 6 and then subtracting the value on line 10.

430.5 - Completing Lines Twelve Through Seventeen - Reason for Denial
(Rev. 6, 08-30-02)
B3-13430.5

Line 12 - Sanctioned From Medicare - The number of applications denied because the applicant is currently excluded/sanctioned from Medicare.

Line 13 - Debarred/Excluded by Other Federal Agency - The number of applications denied because the applicant had been debarred, suspended, or excluded by any other Federal agency.

Line 14 - Not Professionally Licensed - The number of applications denied because the applicant was not professionally licensed.

Line 15 - Business Address Invalid - The number of applications denied because the applicant had an invalid business address.

Line 16 - Business Location Not Licensed - The number of applications denied because the applicant's business location was not properly licensed.

Line 17 - CMS Requirements Not Met - The number of applications denied because the applicant did not meet all CMS requirements.

430.6 - Completing Lines Eighteen Through Twenty-Two - Reason for Return

(Rev. 6, 08-30-02)
B3-13430.6

Line 18 - Incomplete - The number of applications returned to the applicant because the application was incomplete.

Line 19 - Unverifiable Information - The number of applications returned to the applicant because the application included unverifiable information.

Line 20 - Not Signed - The number of applications returned to the applicant because the applicant did not sign the certification statement.

Line 21 - Invalid Billing Agreement - The number of applications returned to the applicant because the billing agreement did not meet CMS requirements.

Line 22 - Other - The number of applications returned to the applicant for any reason other than the ones indicated on lines 18 through 21.

430.7 - Completing Lines Twenty-Three Through Twenty-Six - Application Processing Times

(Rev. 6, 08-30-02)
B3-13430.7

Line 23 - Number Under 21 Days - The number of applications processed in less than 21 days from the date of receipt.

Line 24 - Number in 21-30 Days - The carrier enters the number of applications processed in 21 through 30 days from the date of receipt.

Line 25 - Number in 31-40 Days - The number of applications processed in 31 through 40 days from the date of receipt.

Line 26 - Number Over 40 Days - The number of applications processed in more than 40 days from the date of receipt.

430.8 - Completing Lines Twenty-Seven Through Thirty-Four - Denials Appealed

(Rev. 6, 08-30-02)
B3-13430.8

Line 27 - Pending End of Last Quarter - The CROWD system will automatically enter the value from line 34 on the previous quarter's report.

Line 28 - Adjustments - If it is necessary to revise the pending figure for the close of the previous quarter because of inventories taken or reporting errors discovered, the carrier enters the adjustment here. Adjustments can be positive or negative values. If entering a negative value, it precedes the number with a minus (-) sign.

Line 29 - Adjusted Opening Pending - The CROWD system will automatically sum the values on lines 27 and 28.

Line 30 - Appeals Received - The number of appeals of previously denied applications received during the reporting quarter.

Line 31 - Denials Sustained - The number of appeals processed for which the carrier sustained the initial denial.

Line 32 - Denials Overturned - The number of appeals processed for which the carrier overturned the initial denial.

Line 33 - Total Appeals Processed - The CROWD system will automatically sum the values on lines 31 and 32.

Line 34 - Pending End of Quarter - -The CROWD system will automatically compute the number of appeals pending at the end of the reporting quarter by adding the value on line 29 to the value on line 30 and then subtracting the value on line 33.

430.9 - Exhibits

(Rev. 6, 08-30-02)

B3-13430.9

Exhibit 1 - Screens 1 and 2 of Carrier Provider Enrollment Quarterly Workload Report

CARRIER NAME: CONTRACTOR NUMBER:

REPORT PERIOD: CROWD FORM 4

Workload Operations	Total 1	Physician 2	Group 3	Cert Nurse M-W 4	Cert RNA 5
1. Pending End of Last Quarter					
2. Adjustments					
3. Adjusted Opening Pending					
4. New Applications Received					
5. Returned Apps Resubmitted					
6. Total Applications Received					
7. Applications Approved					
8. Applications Denied					
9. Applications Returned					
10. Total Applications Processed					
11. Pending End of Quarter					

SCREEN 1

CARRIER NAME: CONTRACTOR NUMBER:

REPORT PERIOD: CROWD FORM 4

Workload Operations	Nurse Prac 6	Ambulance 7	Audiologist 8	Ind Phys Ther 9	Ind Occ Ther 10
1. Pending End of Last Quarter					
2. Adjustments					
3. Adjusted Opening Pending					
4. New Applications Received					
5. Returned Apps Resubmitted					
6. Total Applications Received					
7. Applications Approved					
8. Applications Denied					
9. Applications Returned					
10. Total Applications Processed					
11. Pending End of Quarter					

SCREEN 2

Exhibit 2 - Screens 3 and 4 of Carrier Provider Enrollment Quarterly Workload Report

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	Ind Clin Psych 11	Lic Clin SW 12	Cert Nurse Sp 13	Ind Phys Lab 14	Phys Asst 15
Workload Operations					
1. Pending End of Last Quarter					
2. Adjustments					
3. Adjusted Opening Pending					
4. New Applications Received					
5. Returned Apps Resubmitted					
6. Total Applications Received					
7. Applications Approved					
8. Applications Denied					
9. Applications Returned					
10. Total Applications Processed					
11. Pending End of Quarter					

SCREEN 3

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	MSC 16	ASC 17	PH/W Agency 18	VH/C Agency 19	Ind Psych 20
Workload Operations					
1. Pending End of Last Quarter					
2. Adjustments					
3. Adjusted Opening Pending					
4. New Applications Received					
5. Returned Apps Resubmitted					
6. Total Applications Received					
7. Applications Approved					
8. Applications Denied					
9. Applications Returned					
10. Total Applications Processed					
11. Pending End of Quarter					

SCREEN 4

Exhibit 3 - Screens 5 and 6 of Carrier Provider Enrollment Quarterly Workload Report

CARRIER NAME:		CONTRACTOR NUMBER:		
REPORT PERIOD:		CROWD FORM 4		
	Port X-Ray 21	Ind Clin Lab 22	Unk Supp/Prov 23	Flu Imm Biller 24
Workload Operations				
1. Pending End of Last Quarter				
2. Adjustments				
3. Adjusted Opening Pending				
4. New Applications Received				
5. Returned Apps Resubmitted				
6. Total Applications Received				
7. Applications Approved				
8. Applications Denied				
9. Applications Returned				
10. Total Applications Processed				
11. Pending End of Quarter				

SCREEN 5

CARRIER NAME:		CONTRACTOR NUMBER:			
REPORT PERIOD:		CROWD FORM 4			
	Total 1	Physician 2	Group 3	Cert Nurse M-W 4	Cert RNA 5
Reasons for Denial					
12. Sanctioned from Medicare					
13. Debarred/Excluded by Other Fed					
14. Not Professionally Licensed					
15. Business Address Invalid					
16. Business Location Not Licensed					
17. HCFA Requirements Not Met					
Reason for Return					
18. Incomplete					
19. Unverifiable Information					
20. Not Signed					
21. Invalid Billing Agreement					
22. Other					

SCREEN 6

Exhibit 4 - Screens 7 and 8 of Carrier Provider Enrollment Quarterly Workload Report

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	Nurse Prac 6	Ambulance 7	Audiologist 8	Ind Phys Ther 9	Ind Occ Ther 10
Reasons for Denial					
12. Sanctioned from Medicare					
13. Debarred/Excluded by Other Fed					
14. Not Professionally Licensed					
15. Business Address Invalid					
16. Business Location Not Licensed					
17. HCFA Requirements Not Met					
Reason for Return					
18. Incomplete					
19. Unverifiable Information					
20. Not Signed					
21. Invalid Billing Agreement					
22. Other					

SCREEN 7

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	Ind Clin Psych 11	Lic Clin SW 12	Cert Nurse Sp 13	Ind Phys Lab 14	Phys Asst 15
Reasons for Denial					
12. Sanctioned from Medicare					
13. Debarred/Excluded by Other Fed					
14. Not Professionally Licensed					
15. Business Address Invalid					
16. Business Location Not Licensed					
17. HCFA Requirements Not Met					
Reason for Return					
18. Incomplete					
19. Unverifiable Information					
20. Not Signed					
21. Invalid Billing Agreement					
22. Other					

SCREEN 8

Exhibit 5 - Screens 9 and 10 of Carrier Provider Enrollment Quarterly Workload Report

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	MSC 16	ASC 17	PH/W Agency 18	VH/C Agency 19	Ind Psych 20
Reasons for Denial					
12. Sanctioned from Medicare					
13. Debarred/Excluded by Other Fed					
14. Not Professionally Licensed					
15. Business Address Invalid					
16. Business Location Not Licensed					
17. HCFA Requirements Not Met					
Reason for Return					
18. Incomplete					
19. Unverifiable Information					
20. Not Signed					
21. Invalid Billing Agreement					
22. Other					

SCREEN 9

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	Port X-Ray 21	Ind Clin Lab 22	Unk Supp/Prov 23	Flu Imm Biller 24
Reasons for Denial				
12. Sanctioned from Medicare				
13. Debarred/Excluded by Other Fed				
14. Not Professionally Licensed				
15. Business Address Invalid				
16. Business Location Not Licensed				
17. HCFA Requirements Not Met				
Reason for Return				
18. Incomplete				
19. Unverifiable Information				
20. Not Signed				
21. Invalid Billing Agreement				
22. Other				

SCREEN 10

Exhibit 6 - Screens 11 and 12 of Carrier Provider Enrollment Quarterly Workload Report

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	Total 1	Physician 2	Group 3	Cert Nurse M-W 4	Cert RNA 5
Application Processing Times					
23. # under 21 Days					
24. # in 21-30 Days					
25. # in 31-40 Days					
26. # over 40 Days					
Denials Appealed					
27. Pending End of Last Quarter					
28. Adjustments					
29. Adjusted Opening Pending					
30. Appeals Received					
31. Denials Sustained					
32. Denials Overturned					
33. Total Appeals Processed					
34. Pending End of Quarter					

SCREEN 11

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	Nurse Prac 6	Ambulance 7	Audiologist 8	Ind Phys Ther 9	Ind Occ Ther 10
Application Processing Times					
23. # under 21 Days					
24. # in 21-30 Days					
25. # in 31-40 Days					
26. # over 40 Days					
Denials Appealed					
27. Pending End of Last Quarter					
28. Adjustments					
29. Adjusted Opening Pending					
30. Appeals Received					
31. Denials Sustained					
32. Denials Overturned					
33. Total Appeals Processed					
34. Pending End of Quarter					

SCREEN 12

Exhibit 7 - Screen 13 and 14 of Carrier Provider Enrollment Quarterly Workload Report

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	Ind Clin Psych 11	Lic Clin SW 12	Cert Nurse Sp 13	Ind Phys Lab 14	Phys Asst 15
Application Processing Times					
23. # under 21 Days					
24. # in 21-30 Days					
25. # in 31-40 Days					
26. # over 40 Days					
Denials Appealed					
27. Pending End of Last Quarter					
28. Adjustments					
29. Adjusted Opening Pending					
30. Appeals Received					
31. Denials Sustained					
32. Denials Overturned					
33. Total Appeals Processed					
34. Pending End of Quarter					

SCREEN 13

CARRIER NAME: CONTRACTOR NUMBER:
REPORT PERIOD: CROWD FORM 4

	MSC 16	ASC 17	PH/W Agency 18	VH/C Agency 19	Ind Psych 20
Application Processing Times					
23. # under 21 Days					
24. # in 21-30 Days					
25. # in 31-40 Days					
26. # over 40 Days					
Denials Appealed					
27. Pending End of Last Quarter					
28. Adjustments					
29. Adjusted Opening Pending					
30. Appeals Received					
31. Denials Sustained					
32. Denials Overturned					
33. Total Appeals Processed					
34. Pending End of Quarter					

SCREEN 14

Exhibit 8 - Screen 15 of Carrier Provider Enrollment Quarterly Workload Report

CARRIER NAME:	CONTRACTOR NUMBER:			
REPORT PERIOD:	CROWD FORM 4			
	Port X-Ray 21	Ind Clin Lab 22	Unk Supp/Prov 23	Flu Imm Biller 24
Application Processing Times				
23. # under 21 Days				
24. # in 21-30 Days				
25. # in 31-40 Days				
26. # over 40 Days				
Denials Appealed				
27. Pending End of Last Quarter				
28. Adjustments				
29. Adjusted Opening Pending				
30. Appeals Received				
31. Denials Sustained				
32. Denials Overturned				
33. Total Appeals Processed				
34. Pending End of Quarter				

SCREEN 15

Monthly Statistical Report on Medicare Secondary Payer Savings

440 - Monthly Carrier Report on Medicare Secondary Payer Savings (Form CMS-1564)

(Rev. 6, 08-30-02)
B3-13450

440.1 - General

(Rev. 188, Issued: 04-22-11, Effective: 07-01-11, Implementation: 07-05-11)

NOTE: For MSP reporting effective July 2011 for carriers/Part B MACs and October 2011 for DME MACs, refer to the manual instructions located within Publication 100-05, Chapter 5, Section 60 (MSP Reports).

Each month the carrier electronically transmits to CO a Monthly Report on Medicare Secondary Payer Savings (CMS-1564) via the IBM PC. It continues to use existing dialup instructions and the RLINK software sent to it. (See §440.9). Hard copy reports are not required. It transmits a separate report for each office assigned a separate carrier number. When its service area covers more than one State, however, it transmits a separate report for each State even though it has been assigned only one number. It is not required to complete an individual State report for those States in which it has had no MSP activity during the month (reports that would show zeros in every cell, including pending).

440.2 - Purpose and Scope

(Rev. 6, 08-30-02)
B3-13450.2

The Monthly Carrier Report on Medicare Secondary Payer Savings supplies CMS with current data on MSP savings and MSP pending workloads.

440.3 - Due Date

(Rev. 6, 08-30-02)
B3-13450.3

Form CMS-1564 is due in CMS as soon as possible after the end of the reporting month, but no later than the 15th of the following month. Nonreceipt of the report by the due date will result in a telephone contact with the carrier to obtain the report data.

440.4 - Form Heading

(Rev. 6, 08-30-02)
B3-13450.4

The carrier enters its name, assigned number and the State in which the provider is located. In the space labeled "Reporting Period" it enters the numeric designation for month and year for which the report is prepared, e.g., show 01/02 for January 2002.

440.5 - Savings Calculations

(Rev. 6, 08-30-02)
B3-13450.5

Reporting Dollar Values - The carrier rounds values to the nearest whole dollar. This includes all amounts shown on lines 2, 4, 6, 8 and 10.

Checking Reports - Before mailing the reports, the carrier checks their completeness and accuracy as follows:

- Lines 1 + 3 + 5 = line 7 for all columns.

- Lines 2 + 4 + 6 = line 8 for all columns.

- Line 10 should be equal to or greater than line 9 for all columns, unless line 9 is equal to "0" in any column; in that case, line 10 should also be equal to "0" for the same column.

- For each line of the report, column "I" (TOTAL) must equal the sum of the items in columns "ii" + "iii" + "iv" + "v" + "vi."

440.6 - Recording Savings

(Rev. 6, 08-30-02)
B3-13450.6

The carrier controls all claims from which it extracts MSP savings and is able to verify all amounts recorded on the CMS-1564.

MSP Savings File - The carrier retains claims specific key identifying information on each claim counted as savings on the CMS-1564. At a minimum, it records the beneficiary's name, HICN, claim control number, type/dates of service, billed charges and savings amounts reported.

Savings Data from Non-Medicare Sources - If the carrier records savings from data which it has obtained from its "private side" records or any other "outside" source, it must be able to extract the same claims specific information noted above; i.e., it must verify that Medicare covered services are involved and be able to calculate "what Medicare would have paid." In addition, it compares these data with the data contained in its MSP savings file to ensure that savings have not previously been recorded for the same claim. If savings have not previously been taken, it counts them as savings on the CMS-1564 and enters them into its MSP savings file.

440.7 - Source of Savings

(Rev. 6, 08-30-02)
B3-13450.7

The carrier reports data by total and by source as shown below:

Column (i)	**Total** - All MSP savings regardless of source.
Column (ii)	**Worker's Compensation, Black Lung, and VA** - Data related to all MSP savings resulting from medical benefits provided by the WC Plans of the 50 States, the District of Columbia, Guam and Puerto

	Rico. Also included is Federal WC provided under the Federal Employee's Compensation Act, the U. S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal BL Program), and any fee-for-service medical care paid for by the VA. The carrier keeps separate records for each distinct category (WC, BL or VA) as this may become a reporting requirement in the future.
Column (iii)	**Working Aged** - The carrier includes data related to all MSP savings resulting from benefits payable under an EGHP for beneficiaries aged 65 and older who are covered by reason of their own employment or the employment of a spouse of any age. **Medicare Claims Processing**, Chapter 28, **Coordinating With Medicaid and Medigap Insurers** further defines the individuals subject to this limitation on payment.
Column (iv)	**ESRD** - The carrier includes data related to all MSP savings resulting from benefits payable under an EGHP for individuals who are entitled to Medicare benefits solely on the basis of ESRD during a period of up to 12 months. The period during which Medicare pays benefits is defined in **Medicare Claims Processing**, Chapter 28, **Coordinating With Medicaid and Medigap Insurers.**
Column (v)	**Auto Medical, No Fault and Liability Insurance** - The carrier includes data related to all MSP savings resulting from both: **Automobile Medical or No Fault Insurance** - Insurance coverage (including a self-insured plan) that pays for all, or part, of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile, regardless of who may have been responsible for the accident. (This insurance is sometimes called "personal injury protection," "medical payments coverage" or "medical expense coverage.") **Liability Insurance** - Insurance (including a self-insured plan) that provides payment based on legal liability for injury, illness, or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. It does not include situations where a beneficiary receives medical payment under his or her own homeowner's insurance.
Column (vi)	**Disabled** - The carrier includes data related to all MSP savings resulting from situations where Medicare is the secondary payer for disabled beneficiaries under age 65 (except ESRD beneficiaries) who elect to be covered by a large group health plan (LGHP) as a current employee or family member of such employee. A LGHP is any health plan that covers employees of at least one employer who normally employs 100 or more employees. The disabled provisions apply to items and services furnished on or after January l, 1987 and before January l, 1992.

440.8 - Type of Savings

(Rev. 6, 08-30-02)
B3-13450.8

The carrier reports data by type of savings as shown below.

Unpaid (Cost Avoided) MSP Claims

Unpaid (cost avoided) claims are those that the carrier returned without payment because it has strong evidence that another insurer is the primary payer and there is no indication that payment has been requested from that payer. Any information the carrier obtains from a non-Medicare source and uses as the basis for claiming cost avoidance savings must meet the criteria in §440.6B.

Information considered adequate for claiming cost avoidance savings includes statements on the claim noting "automobile accident," "collision", or the name of an automobile insurer. The carrier does not count claims it develops as "possible" MSP situations based on routine edits as cost avoidance savings unless it has previous information that another payer has primary responsibility. For example, "trauma code" edits are not, by themselves, considered strong evidence that Medicare is the secondary payer.

Line 1 - Number - The total number of cost avoided claims from which it is recording savings on the report.

Line 2 - Dollar Value - The total dollar value of the potential Medicare payments calculated for the claims on Line 1 that will be saved if the primary payer makes a payment which relieves Medicare of all payment liability.

The carrier shows as the cost avoided amount what Medicare would have paid. **It does not count total charges as cost avoided savings**. It reduces the cost avoided amount based upon reasonable charge and coinsurance calculations:

- **Reasonable Charge Reductions** - The reasonable charge amount may be calculated through the actual reasonable charge methodology or through a "reasonable charge reduction factor" which is the percentage derived from the most current CMS-1565A by dividing Line 3 (Total Amount of Reduction) by Line 1 (Total Covered Charges for All Claims). (See 240.2.)

- **Coinsurance** - The carrier reduces line items subject to the Part B coinsurance by that amount **or** apply a "coinsurance reduction factor" of 19 percent to all charges.

The carrier may assume that the deductible has been met.

Tracking/Adjusting Cost Avoidance Savings

Cost avoidance savings may not duplicate savings reported as full or partial recoveries and may not be shown where Medicare ultimately makes primary payment. To prevent duplicate counting, the carrier suspends all claims which it returns unpaid. It sets up a control on the claim when it is returned for development. It maintains this control for 75 days, unless it receives further information before that time allowing it to process the claim. If no further information on the claim is received after 75 days, it denies the claim. It is not required to continue tracking the claim, but retains the key identifying information on the claim, as described in §440.6A.

The CMS prefers the carrier to show cost avoidance savings only after 75 days have elapsed. The carrier does, however, have the option of counting the savings when the claim is initially suspended or at any time during the suspension period. If it chooses the latter alternative, it must adjust its cost avoidance savings if the claim is resubmitted during the suspension period with information showing it is not a legitimate cost avoidance.

NOTE: Nonassigned claims may not be returned to beneficiaries (see §3311), but must be controlled as described above when being developed for MSP involvement and counted as cost avoidance savings.

The following situations require special consideration if cost avoidance savings are counted before the 75 day suspense period has ended:

- A claim returned (and counted as cost avoided) is paid **in part** by another payer and the submitter resubmits it for secondary payment.

- A claim returned (and counted as cost avoided) is denied by the other payer and the submitter resubmits it for primary payment.

- A claim returned (and counted as cost avoided) is paid **in full** by the other payer and the provider or some other source informs the carrier of this. The carrier shows "full recovery" savings and not cost avoidance.

In these situations the carrier adjusts its cost avoidance savings figures by deducting or "backing out" the applicable amounts. It makes the adjustments in the reporting month in which a final determination is rendered. The following chart outlines the correct reporting of savings in each situation:

ADJUSTMENTS TO REPORTED MSP COST AVOIDANCE SAVINGS

CLAIMS PROCESSING ACTIONS		MSP SAVINGS REPORTED	
	Cost Avoidance	**Partial Recoveries**	**Full Recoveries**
I. Partial Recovery Adjustment			
MSP situation indicated. Medicare's payment calculated to be $50 if Medicare was primary payer. Claim is returned to submitter.	$ 50		
Claim is resubmitted showing $30 paid by the other insurer. a Medicare secondary payment of $20 is made.	$(50) *	$ 30	
II. "Other" Payer Denial Adjustment			
MSP situation indicated - Medicare's "primary" payment calculated to be $75. Claim is returned to submitter.	$ 75		
Other payer denies claim. Medicare found to be primary and Medicare payment of $75 is made.	$ (75)*		
III. Full Recovery Adjustment			
MSP situation indicated - Medicare's "primary" payment calculated to be $80. Claim is returned to submitter	.$ 80		
Provider or other source informs carrier that full payment was made by the other payer.	$ (80)*		$ 80

*Amounts "backed out" of cost avoidance savings figures.

Full Recoveries

Line 3 - Number - The number of full recoveries made during the month.

Line 4 - Dollar Value - The dollar value of full recoveries made during the month.
Full recoveries represent savings from claims where the primary payer made a payment which relieved Medicare of all payment liability. They can be either prepayment or post-payment. The carrier counts full recoveries in the month in which it renders a final determination on the claim. In post payment situations this is when it has recovered the full amount paid by Medicare. In prepayment situations it is when it receives documentation showing that an MSP resource made a payment equal to or greater than what Medicare would have paid.

a. Prepayment Full Recovery - a prepayment full recovery occurs when an MSP resource makes full payment on a charge before Medicare makes any payment.

EXAMPLE: A physician identifies an EGHP as the primary payer, submits the bill to that insurer, and the EGHP pays the charges in full. The beneficiary informs the carrier of this and submits a copy of the EGHP EOB. The carrier determines what it would have paid if the EGHP had not made payment and records that total as full recovery savings.

1. Post payment Full Recovery - a post payment full recovery occurs when an MSP resource makes full payment on a charge after Medicare has paid.

EXAMPLE: Medicare paid a physician's bill for charges incurred as a result of an automobile accident. Subsequently an auto liability insurer reimburses the Medicare beneficiary for the full amount and the beneficiary refunds that amount to the carrier. The carrier counts the amount of initial payment as a post payment full recovery.
It records as savings, that portion of a full recovery paid to an attorney or other agent as Medicare's share of the recovery cost. When it refers a case to the RO for recovery action, however, it does not record any savings at that point. Savings from a compromise or "subrogation" case may be recorded only after a final determination. The carrier does not count these cases for CPEP credit prior to final settlement.

EXAMPLE: A beneficiary incurs a $1,000 physician's bill and a $5,000 hospital bill as a result of injuries sustained in an automobile accident. Assuming that all deductibles are satisfied, Part B pays $800 toward the physician's charges, and Part A covers the hospital bill in full. After litigation, a liability insurer agrees to pay $6,000 for the beneficiary's medical expenses from which the attorney will take a fee. (If the attorney's fee were 33 percent, the actual dollar recovery would be $4,000.) The carrier records $800 in Full Recovery savings (Part Bs full payment). The intermediary is able to count its payment as a Full Recovery savings even though the actual amount recovered, due to the attorney's fee did not equal what the intermediary paid.

Partial Recoveries

Line 5 - Number - The number of partial recoveries made during the month.

Line 6 - Dollar Value - The dollar value of partial recoveries made during the month.

Partial recoveries are those savings realized when a primary payer makes a payment which covers only a part of the Medicare allowable charge, leaving Medicare with a balance to pay. The carrier uses the following formula in computing the savings from a partial recovery:

- The dollar amount of Medicare benefits available for the services or supplies (calculated as if Medicare were the primary payer) less the Medicare benefits paid for the services or supplies equals the partial recovery savings.
  (Primary Payment - Actual Payment = Partial Recovery Savings)

It counts partial recoveries in the month when it takes final action on the claim (either making a payment supplemental to that of the primary payer or making a partial recovery from a payment by the primary payer) on the claim. Instructions for processing partial recovery claims are in Medicare Claims Processing, Chapter 28, Coordination with Medicaid and Medigap Insurers.

The carrier records as savings, that portion of a partial recovery paid to an attorney or other agent as Medicare's share of the recovery cost. When it refers a case to the RO for recovery action it does not record any savings at that point. Savings from a compromise or "subrogation" case may be recorded only after a final determination. These cases may not be counted for CPEP credit prior to reaching final settlement.

Totals

In this part of the report (lines 7 and 8), the carrier reports data on the totals of unpaid claims plus full and partial recoveries.

Line 7 - Claims - The total number of MSP claims handled during the month.

Line 8 - Dollar Value - The total dollar value associated with MSP claims during the month.

Pending Claims/Cases

Line 9 - Number - The number of pending claims/cases as of the close of the month. This includes claims/cases for which "Full Recovery" is expected but all money due has not been received.

Line 10 - Estimated Value - The gross charges for all claims/cases reported as pending on line 9. Where "Full Recovery or Partial Recovery" has been determined, but all monies have not been received, the carrier reports the gross charges until it receives the full amount due or it is reasonable to expect no further payments.

A case is defined as one or more claims filed on behalf of an individual and related to one specific occurrence which necessitated medical care. When recording data for column 1 concerning WC and Auto Liability, and No Fault Insurance, the carrier counts only cases. For Working Aged (column iii), ESRD (column iv), and Disabled (column vi), it counts each individual claim.

A case/claim is considered pending only after it has been developed to the point where it is determined to be an MSP claim and no final resolution has been made. A partial or interim payment is not sufficient to remove a case/claim from the pending rolls. Final resolution occurs when there is no longer a practical expectation of further reimbursement by another resource.

Remarks - The carrier enters any comments relevant to the interpretation and analysis of this report.

Signature - The report should be signed by the individual responsible for its compilation.

Date - Date the report is completed and signed.

440.9 - Electronic Submission

(Rev. 6, 08-30-02)
B3-13450.9

A. Keying CMS-1564 - The carrier:

- Uses existing RLINK dialup instructions.
- Keys letter "K" to bring up blank CMS-1564.
- Enters valid 5 digit carrier number. It uses the tab key to move from column to column.
- Enters reporting period using numeric designation for month and year, e.g., 0102 for January 2002.
- Enters two-position alpha State code.
- Completes each column of data. Fields with zero do not have to be keyed. System will presume all blank fields to be zero.
- Does not key dollar signs or commas. Keys only whole dollar amounts.
- After completing the form, the carrier keys F1. System edits and prints any error messages on the line above "contractor number." The carrier tabs to incorrect field and rekeys correct entry. When form passes all edits, line will read "record has been written." Carrier keys F4 to return to menu.
- To abort at any time without writing a record, the carrier keys F3 and refers to CICS instructions.
- To verify that a report has been written, the carrier returns to the main menu (F4) and keys "K" to bring up a blank form. It keys in contractor number, reporting period and State code. It keys F7. Completed report should appear on the screen.

B. Edits for CMS-1564:

- A valid 5-digit carrier number is required.
- The default value for areas not keyed is zero.
- Appropriate reporting period (MMYY) is required.
- Two-position alpha State code required.
- Lines 1 + 3 + 5 must equal line 7 for all columns.
- Lines 2 + 4 + 6 must equal line 8 for all columns.
- Line 10 must be equal to or greater than line 9 for all columns, unless line 9 is zero. In that case line 10 must also be zero.
- For each line of the report column I must equal the sum of columns ii + iii + iv + v + vi.

440.10 - Exhibit
(Rev. 6, 08-30-02)
B3-13450.10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

MONTHLY CARRIER REPORT ON MEDICARE SECONDARY PAYER SAVINGS

CARRIER NAME	NUMBER	STATE	REPORTING PERIOD (MO.

	TOTAL (i)	WORKER'S COMP. BLACK LUNG & VA (ii)	WORKING AGED (iii)	ESRD (iv)	AUTO MED. NO FAULT AND LIABILITY (v)	DISABL (vi)
Unpaid (Cost Avoided) MSP Claims 1. Number						
2. Dollar Value						
Full Recoveries 3. Number						
4. Dollar Value						
Partial Recoveries 5. Number						
6. Dollar Value						
Special Projects 7. Number						
8. Dollar Value						
Totals 9. Number (Lines 1 + 3 + 5 + 7)						
10. Dollar Value (Lines 2 + 4 + 6 + 8)						

REMARKS

SIGNATURE	TITLE	DATE

Form HCFA-1584 (8-90)

450 – Medicare Contractor Transaction Report (Form CMS-5)
(Rev. 36, 03-12-04)

Intermediaries and carriers must prepare and submit to CMS each month the Medicare Contractor Transaction Report (CMS Form 5) showing their Electronic Data Interchange (EDI) and manual transactions workload under the health insurance program. A separate report is required for each office assigned a separate contractor number.

450.1 – Due Date
(Rev. 36, 03-12-04)

The report is transmitted to central office via PC or terminal as soon as possible after the end of the month being reported but no later than the 15th of the following month. Use instructions in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.

450.2 - Heading
(Rev. 36, 03-12-04)

The report is referenced as Form 5 in the CROWD system. The intermediary or carrier completes the ADD/UDATE/DELETE criteria screen with the appropriate information to bring the reporting format to its screen.

450.3 – Body of Report
(Rev. 171, Issued 05-28-10, Effective: 01-01-11, Implementation: 10-04-10 /01-03-11 VMS-analysis and design)

A. General Report Content Requirements

The words "adjudicated," "processed to completion" and "processed" are used in some of the instructions for completion of CROWD Form 5. A claim is considered to be "adjudicated" or "processed to completion" on the date of its payment (date a check is produced or EFT authorization is issued), or the date the remittance advice is issued in the event no check/EFT was due. An NCPDP claim is considered "processed" on the date when it has passed all front end edits and is passed to the Core System for processing.

Every column in Form 5 does not apply to each type of data, and there are different types of columns in some areas of the report. No data is to be entered into any shaded fields.

All of the data to be reported on Form 5 is for the prior calendar month. Form 5 data must be entered by carriers, DME MACs, A/B MACs and FIs by the 15th of each month. Data due from a shared system or from CWF must be available for carrier, DME contractor, A/B MAC or FI use by the 5th of the month following the month during which the data were collected. Certain types of data must be collected by individual carriers, DME MACs, A/B MACs or FIs. When applicable, that data must also be tracked for each calendar month.

Institutional and professional blocks have been added to the identification area at the top of the form. A/B MACs process both institutional and professional claims but are expected to separately report their professional and institutional data in CROWD. One CROWD Form 5 must be submitted for professional data and another for institutional data. This corresponds to the separate professional and institutional reporting always done by carriers and FIs. Every CROWD Form 5 submitted must have a check mark next to either institutional or professional. This will enable CMS to compare statistics received from the A/B MACs against historical data separately submitted by carriers and FIs.

B. Line and Column CROWD Form 5 Completion Requirements

CROWD reports must be submitted by carriers, DME MACs, A/B MACs and FIs. They cannot currently be filed by shared system or CWF maintainers. Appropriate rows have been identified for the reporting of 4010A1 data. Appropriate additional rows have also been added to allow for the reporting of version 5010 data. Where no version is appropriate for a row (i.e. IVR), there is no version listed.

Line 1 – Responses to Claim Status Inquiries – Shared systems must track the number of claim status flat file responses sent to each of their carriers, DME MACs, A/B MACs and FIs for translation into X12 277 transactions. Each carrier, DME contractor, A/B MAC and FI is to report that total in column 1. Shared systems are to count each occurrence of the unique trace or claim transaction number (ICN/DCN/CCN) as assigned by the provider (e.g., in the 277, use TRN02 or REF02 of the 2200E loop) as a separate claim status response. Include both positive (able to furnish requested status) as well as negative (unable to furnish requested status for some reason, such as unable to locate a claim for that HIC on that day) responses in the count, but do not include queries that were rejected as incomplete or incorrect.

Contractors participating in an Internet pilot that involves claim status data do not obtain their information from a shared system and do not record responses by transaction number (DCN or CCN). They are to track responses by HIC instead. Pilot contractors must report on line 1, column 3, the total of HICs for which they issued claim status responses during the prior month. They are to include both positive (able to furnish requested status) as well as negative (unable to furnish requested status for some reason) responses in the count, but must exclude any claim status responses that may have been issued via means other than the Internet in the total reported in column 3. Since it would be very difficult or even impossible for Internet pilot contractors to track responses issued by State, those contractors are permitted to report all Internet responses they issued under the primary contract number that applies to that company, i.e., the contract number under which funding is issued to the contractor by CMS.

Line 2 – Responses to Eligibility Inquiries – Shared systems are to track the number of eligibility responses they may send in a flat file to each of their carriers, DME MACs, A/B MACs and FIs for issuance electronically in legacy formats. Shared systems must exclude from their carrier, DME contractor, A/B MAC and FI totals, the number of these eligibility flat file records produced using CWF HUQA responses. Carriers, DME MACs, A/B MACs and FIs are to report the shared system total in column 1. Eligibility responses to be issued via DDE, IVR, or the Internet must also be excluded from the line 2, column 1 total. DDE and IVR totals are to be entered on line 14. Each unique occurrence of an individual beneficiary HIC number must be counted as a separate eligibility response. A response indicating that no record could be located for a beneficiary is considered a valid response. Include both positive (able to furnish eligibility information) as well as negative (unable to furnish eligibility information) responses in the count.

Contractors that operate a pilot to allow providers to obtain beneficiary eligibility data via the Internet must track the number of individual Internet eligibility responses they issue. Each unique occurrence of an individual beneficiary HIC number must be counted as a separate eligibility response. Eligibility responses issued via non-Internet DDE/PPTN/PINQ or an IVR must be excluded from the monthly total reported in column 3. Since it would be very difficult or even impossible for Internet pilot contractors to track responses issued by State, those contractors are permitted to report all Internet responses they issued under the primary contract number that applies to that company, i.e., the contract number under which funding is issued to the contractor by CMS.

Line 3 – HUQA Eligibility Responses--In lieu of use of DDE or the 270/271, a number of clearinghouses and large providers have been permitted to submit eligibility queries directly to data centers to obtain beneficiary eligibility data from CWF. The incoming query identifies the contractor responsible for processing of claims for the provider requesting the eligibility data, enabling the CWF maintainer to track and notify each contractor of the total number of clearinghouse and provider HUQA eligibility responses processed through CWF.

Contractors sometimes request HUQAs for local purposes also. Contractors are to report the number of HUQA eligibility responses issued by CWF for beneficiaries in their service area on line 3. This CWF number must include HUQAs sent to clearinghouses or large providers through the data centers, as well as HUQAs that the contractors might have requested to obtain beneficiary eligibility data for other purposes. The CWF maintainer must report the number of HUQA responses issued in the CWF operating report (ORPT) file.

> **NOTE:** RACF clearance is needed for access to the ORPT file. Contractor staff members assigned to CWF have access to this file. Staff members in the EDI department that do not have access to this file should be able to obtain this CWF data through their CWF colleagues or by obtaining RACF clearance through their security office to access this file.

Line 4—Reserved for future reporting needs.

NOTE: Lines 5, 6 and 7 are to be completed by DME MACs only.

Line 5 – Prior Authorizations or Advance Determination of Medicare Coverage Requests – DME MACs are to track and report the number of these decisions issued. (This count must exclude telephone discussions about Medicare coverage, but include those cases which result in issuance of specific prior authorization or advance determination decisions.) If any of these decisions are issued electronically, that total must be reported in column 1. Manually issued prior authorization decisions are to be reported in column 2.

Line 6 – National Council of Prescription Drug Plans (NCPDP) Retail Pharmacy Drug Claims Processed – VMS must track the number of NCPDP claims processed. VMS is to count each unique occurrence of a claim control number as a separate claim. The DME MACs are to report this number in column 1.

Line 7 –Reserved for future reporting needs.

NOTE: Lines 8-11 and 13-15 apply to all carriers, DME MACs, A/B MACs and FIs. Line 12 applies to FIs and A/B MACs only.

Line 8 – Remittance Advices--Number Sent – Shared systems are to track the number of 835 flat files sent their carriers, DME MACs, A/B MACs or FIs. They must report each occurrence of an 835 ST to SE segment set as a separate electronic remittance advice (ERA) transaction for counting purposes. If a provider is sent both an electronic and a paper remittance advice for the same group of claims, they are to count them separately as one electronic and one non-electronic remittance advice. The carriers, DME MACs, A/B MACs and FIs must report the total number of ERAs in column 1.

The shared system must also track the number of standard paper remittance (SPR) files sent their users for printing in each calendar month. Carriers, DME MACs, A/B MACs and FIs must report this total in column 2.

As result of termination of the Medicare electronic remittance HIPAA contingency plan effective October 1, 2006, an entry is no longer required in column 3 by any carriers, DME MACs, A/B MACs or FIs.

The total number of remittance advice records furnished via the Internet is to be reported in column 4. A future CR is expected concerning a pilot for reporting of remittance advice information on the Internet for access by the provider for which the record is prepared. In anticipation of this requirement, a field has been added for reporting of the total number of Internet remittance advice flat files records that were issued in the prior month. Information concerning responsibility for tracking of this number and the effective date on which reporting of this number will begin will be included in the implementation instruction for use of the Internet for this purpose.

Line 9 – Number of Payments to Providers or Suppliers– Shared systems are to track the number of electronic fund transfers (EFTs) and paper checks for provider claim payments that the carriers, DME MACs, A/B MACs and FIs were to issue. The EFT total must represent the total of all provider claim payments issued via EFTs, regardless if issued in conjunction with an 835 ERA or an SPR. The paper check total must be the total of paper checks sent in conjunction with an SPR or an 835. In some cases, a remittance advice might not have any payment because all the claims were denied, entire payment due a provider is being withheld to recoup an overpayment, or payments to a provider are being held in an escrow account pending completion of an investigation. As result, the number of payments does not always equal the number of SPRs and ERAs issued. Carriers, DME MACs, A/B MACs and FIs must report the EFT total in column 1 and the paper check total in column 2.

Line 10 – Dollar Amounts Associated w/Payments – Shared systems must track the dollar value of the EFTs and checks issued by their carriers, DME MACs, A/B MACs and FIs for provider claim payments each month. The carriers, DME MACs, A/B MACs and FIs must report the dollar value of the EFTs in column1 and of the paper checks in column 2.

Line 11 – Electronic Claims Processed—Shared systems must track the following information which each carrier, DME contractor, A/B MAC and FI must enter as indicated in form 5:

- In the first column, the total of processed electronic X12 837 claims (exclude DDE claims sent to FIs).

- In the second column, all electronic claims processed that were submitted via DDE screens. (DDE claims are considered HIPAA-compliant, but are to be reported separately here from the number of received 837 claims.) Non-FIs, who do not accept claims via DDE, must enter zero.

  NOTE: For lines 12-14, shared systems, carriers, DME MACs, A/B MACs and FIs must limit reporting to those transactions for which their providers can obtain the type of data noted using DDE (exclude those CWF HUQA eligibility responses reported on line 3) or an IVR. Medicare contractors that do not offer a DDE screen or IVR for the type of information listed on a particular unshaded line must enter zero. CWF uses HIQA, ELGA, ELGB and ELGH queries to respond to DDE eligibility requests. The CWF maintainer must report the monthly total of each of those response types in the ORPT file for carrier, FI, DME MAC or A/BMAC access.

Line 12—DDE Claim Adjustments Received—FISS must track the number of adjustments submitted via DDE for claims (it does not matter for reporting in this line whether the claims themselves were submitted via DDE). If multiple adjustments are made during the same connection session to the same claim, they must be reported as one adjustment. If multiple claims are adjusted during the same session by a provider or clearinghouse, FISS must count each claim separately regardless of the number of fields modified in each of those claims. The FIs and A/B MACs must report the total number of adjustments in column 2.

Line 13—DDE/IVR Claim Status Responses—Shared systems must track the number of claim status responses issued via a DDE screen. Carriers, DME MACs, A/B MACs and FIs must report that number in the second column. If a provider can use a single claim status DDE screen to obtain status information for multiple claims during the same session, the shared systems must count each claim for which status information is supplied as a separate query response. The carrier, DME contractor, A/B MAC or FI must report that number in the second column.

If a shared system supplies claim status data for reporting via IVR, the shared system must track those responses and the carrier, DME contractor, A/B MAC or FI must report that number in the third column. If a carrier, DME contractor, A/B MAC, FI, or a data center, "screen scrapes" shared system data to obtain claim status information used to respond via IVR, a shared system would not be able to record the number of responses issued using that data. In that situation, the carrier, DME contractor, A/B MAC or FI must count the number of these responses issued via IVR and report that number in the third column. Count each HIC/date of service for which status is reported as a separate claim status response.

Line 14—CWF or IVR Eligibility Responses—CWF must track the number of DDE (HIQA, ELGA, ELGB or ELGH) responses issued per carrier, DME contractor, A/B MAC and FI during the prior month as applicable and report the numbers in the CWF ORPT file. Carriers, DME MACs, A/B MACs and FIs must report the CWF total in the second column. If a provider can use a single eligibility DDE screen to obtain information on more than one beneficiary during the same session, each HIC for which eligibility data is furnished must be counted as a separate response by CWF.

If a carrier, DME MAC, A/B MAC or FI obtains eligibility data from their shared system or an alternate source for IVR eligibility responses, that carrier, DME MAC, A/B MAC or FI must track the number of eligibility responses they issue using the shared system and alternate source eligibility data and report that total in the third column of line 14. Alternate sources would include CWF, the CMS central office eligibility database under a pilot and any other eligibility data repository not separately listed here that may be available for the contractor's use. If a provider can request beneficiary eligibility data for multiple beneficiaries during the same IVR session, each HIC for which an eligibility data is issued must be counted as a separate response.

Line 15—Paper Claims Processed—Shared systems shall track the total number of paper claims processed per contractor and each carrier, A/B MAC, DME MAC and FI shall report their UB-04 or CMS-1500 (08/05) total in column 2.

450.4 – Exhibit 1

(Rev. 171, Issued 05-28-10, Effective: 01-01-11, Implementation: 10-04-10 /01-03-11 VMS-analysis and design)

TYPE OF TRANSACTION			**ELECTRONIC**	**NON-ELECTRONIC** (MANUAL PROCESSES)	**INTERNET**
ALL CONTRACTORS					
1. RESPONSES TO CLAIMS STATUS INQUIRIES		**4010A1**			
		5010			
2. RESPONSES TO ELIGIBILITY INQUIRIES (Exclude HUQA)					
3. HUQA ELIGIBILITY RESPONSES					
4. Reserved for Future Use					
DME MACs ONLY					
5. PRIOR AUTHORIZATIONS OR ADVANCED DETERMINATIONS OF MEDICARE COVERAGE ISSUED		**4010A1**			
		5010			
6. NCPDP RETAIL PHARMACY DRUG CLAIMS PROCESSED		**5.1**			
		D.0			
7. Reserved for Future Use					
ALL CONTRACTORS					
8. REMITTANCE ADVICES—NUMBER SENT	**4010A1**	**835**	**SPR**		**Internet RA**
	5010	**835**	**SPR**		**Internet RA**

9. # OF PAYMENTS TO PROVIDERS OR SUPPLIERS		**# EFT**	**# Paper Checks**		
10. DOLLAR AMOUNTS ASSOCIATED W/ PAYMENTS		**EFT $**	**Paper Checks $**		
PROCESSED CLAIMS ACTIONS and DDE/IVR RESPONSES DATA		**HIPAA**	**DDE, HIQA/ ELGA/ELGB/ ELGH, CWF**	**IVR**	
11. ELECTRONIC CLAIMS PROCESSED	**4010A1**				
	5010				
12. DDE CLAIM ADJUSTMENTS REC'D					
13. DDE/IVR CLAIM STATUS RESPONSES					
14. CWF or IVR ELIGIBILITY RESPONSES					
15. PAPER CLAIMS PROCESSED					

460 - Monthly Statistical Report on Intermediary and Carrier Part A and Part B Appeals Activity Form (CMS-2592)

(Rev. 144; Issued: 11-28-08; Effective Date: 04-01-09; Implementation Date: 04-06-09)

	Column 1	Column 2	Column 3
	Part A Services	**Part B Services**	**Part B Services**
	Processed by Intermediary	**Processed by Intermediary**	**Processed by Carrier**
Section I: Redeterminations			
1: Opening Pending			
2: Adjustments to Pending			
3: Adjusted Pending			
4: Requests Received			
5: Misrouted Requests Forwarded to Another Contractor			
6: Requests Cleared			
6.1 Number of Claims Cleared			
a. SNF			
b. Home Health			
c Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
6.2. Recovery Audit Contractor (RAC) Redeterminations Cleared			
6.2.1 Number of RAC			

Claims Involved			
7: Cleared -- Evidence Submitted after Request			
7.1: Number of Claims Involved			
a. SNF (Not Applicable)			
b. Home Health (Not Applicable)			
c. Inpatient Hospital (Not Applicable)			
d. Outpatient (Not Applicable)			
e. Lab (Not Applicable)			
f. Ambulance (Not Applicable)			
g. DME (Not Applicable)			
h. Physician (Not Applicable)			
i. Other (Not Applicable)			
7.2: RAC Redeterminations Cleared With Additional Documentation			
7.2.1: Number of RAC Claims Involved			
8: Affirmations			
8a. Waiver of Liability Amount Paid (Not Applicable)			
8.1: Number of Claims Affirmed			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
8.2 RAC Redeterminations Affirmed			
8.2.1: Number of RAC Claims Involved			
9: Partial Reversals			
9.1: Number of Claims Partially Reversed			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			

e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
9.2: RAC Redeterminations Partially Reversed			
9.2.1: Number of RAC Claims Involved			
10: Full Reversals			
10.1 Number of Claims Fully Reversed			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
10.2: RAC Redeterminations Fully Reversed			
10.2.1: Number of RAC Claims Involved			
11: Dismissals/Withdrawals			
11.1 Number of Claims Dismissed or Withdrawn			
a. SNF			
b. Home Health			
c Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
11.2: RAC Redeterminations Dismissed or Withdrawn			
11.2.1: Number of RAC Claims Involved			
12: Number of Incomplete Redeterminations Requests Dismissed			
13:Medicare Approved Amount (Not Applicable)			
14: Redeterminations Processing Time –Average			

15: Redeterminations Completed in 1-60 days			
15a. RAC Redeterminations Completed in 1-60 days			
16: Redeterminations Completed in Over 60 days			
16 a. RAC Redeterminations Completed in Over 60 days			
17: Redeterminations Processing Time- Average (Documentation Submitted Later)			
18: Redeterminations Completed in 1-60 days (Documentation Submitted Later)			
18a. RAC Redeterminations Completed in 1-60 days (Documentation Submitted Later)			
19: Redeterminations Completed in 61-74 days (Documentation Submitted Later)			
19a. RAC Redeterminations Completed in 61-74 days (Documentation Submitted Later)			
20: Redeterminations Completed in over 74 days (Documentation Submitted Later)			
20a. RAC Redeterminations Completed in over 74 days (Documentation Submitted Later)			
21: Closing Pending Redeterminations			
22 Redeterminations Pending 1-30 days			
23: Redeterminations Pending 31-60 days			
24: Redeterminations Pending 61-74 Days			
25: Redeterminations Pending Over 74 days			
26: Total Effectuations			
26a: Number of Claims Involved			
27: Number Effectuated 1-30 Days			

28: Number Effectuated 31-60 Days			
29: Number Effectuated over 60 Days			
Section II: QIC Reconsiderations			
30: Opening Pending			
31: Adjustments to Pending			
32: Adjusted Opening Pending			
33: Requests For QIC Reconsideration Received by the Contractor			
33a. Misrouted Requests Forwarded to QIC			
33b. Misrouted Requests Forwarded Timely			
33c. Misrouted Requests Forwarded Untimely			
34. Requests from QIC for Case Files			
35: Number of Case Files Forwarded to QIC			
36: Number Forwarded in 1-5 days			
36a: Number Forwarded in 6 Days			
37: Number Forwarded in 7-8 Days			
37a: Number Forwarded in Over8 Days			
38: Average Time to Forward			
39. Pending Case File Requests			
40: Number of QIC Decisions Received from QIC			
41: Number of QIC Decisions that Need Effectuation			
41a. Number of Claims Involved			
42: Total Effectuations			
42a. Number of Claims Involved			
43. Number Effectuated in 1-30 Days			
43a. Contractor Computed Amount			
44: Number Effectuated in 31-60 Days			

44a. Contractor Computed Amount			
45: Number Effectuated in Over 60 Days			
45a: Contractor Computed Amount			
46 Medicare Approved Amount (Not Applicable)			
46a. Waiver of Liability Amount Paid (Not Applicable)			
47: Closing Pending Reconsiderations			
Section III: ALJ Results			
48: Opening Pending			
49: Number of Appeal Requests for ALJ Hearing Misrouted to Contractor			
50: Number of ALJ Decisions Received from Administrative QIC			
51: Number of ALJ Decisions Received that Need Effectuation			
51a Number of Claims Involved			
52: Total Effectuations			
52a. Number of Claims Involved			
53: Number Effectuated in 1-30 Days			
54: Number Effectuated in 31-60 days			
55: Number Effectuated in Over 60 Days			
56: Medicare Approved Amount (Not Applicable)			
56a. Waiver of Liability Amount Paid (Not Applicable)			
57: Closing Pending ALJ Decisions			
Section IV: Medicare Appeals Council Effectuations			
58: Medicare Appeals Council Effectuations			

Clerical Error Reopenings

1: Total Number of Clerical			

Error Reopenings Received			
2: Total Number of Clerical Error Reopenings Processed			
3. Total Number Processed – Own Motion			
4. Total Number Processed – Claimant Initiated			
5: Total Number of Clerical Error Reopenings Resulting from Contractor Error			
6: Total Number of Clerical Error Reopenings Resulting from Provider Error			
7. Reserved for Future Use			
8. Reserved for Future Use			
9. Medicare Approved Amount (Not Applicable)			
10. Clerical Error Reopenings Processed in 1-30 days			
11. Clerical Error Reopenings Processed in 31-60 days			
11.a Clerical Error Reopenings Processed in More than 60 days			
12: Total Number of Clerical Error Reopening Requests Pending			
13. Total Number of Higher Level Reopenings Requiring Adjustment by the Contractor			
14. Amount Awarded (Not Applicable)			

460.1 – General

(Rev. 144; Issued: 11-28-08; Effective Date: 04-01-09; Implementation Date: 04-06-09)

At the end of each month, the contractor prepares and transmits to CMS a report summarizing monthly activity on redeterminations processed by intermediaries and carriers, as well as those actions associated with reconsiderations, and Administrative Law Judge (ALJ) hearings and Part A and Part B Medicare Appeals Council effectuations that are processed by intermediaries and carriers. Contractors shall complete separate reports for each office where a separate intermediary or carrier number has been assigned.

NOTE: The report is NOT designed to be completed by the Qualified Independent Contractor (QIC) or the Administrative Qualified Independent Contractor (AdQIC). All data shall be entered by the contractor except for those lines that are indicated as "Not Applicable" (e.g., Medicare Approved Amount). The data in the "Not Applicable" lines are not required. Contractors shall continue to use the CMS-2591 and CMS-2590 reports to capture data on appeal workloads received prior to the implementation date of the CMS-2592 report. The CMS-2591 and 2590 reports will be used to record appeals related data received prior to the implementation of the CMS-2592 report until all pending appeals workloads have been completed. If a case was received prior to the implementation of the CMS-2592, and as such is captured on the CMS-2591 or CMS-2590, tracking for the case remains on the CMS-2591 or CMS-2590 until all levels of appeal for the case have been completed.

Note: The CMS-2591 and 2590 reports will continue to be used to capture reopenings data that is not clerical in nature, and as such, is not captured on the CMS-2592 report.

Form CMS-2592 is subject to the Paperwork Reduction Act and requires approval by the Office of Management and Budget (OMB). OMB approval has been requested.

Purpose and Scope--The CMS-2592 enables CMS to tabulate data for administrative purposes on the following information.

- The number of redeterminations, reconsiderations, and ALJ hearings requested, completed, and pending;

- The number of redeterminations resulting in affirmations or reversals of previous determinations;

- Timeliness Data (including processing, forwarding and effectuation data at various levels of appeal); and,

- Clerical Error Reopenings Data

Unless specifically indicated, data on the CMS-2592 Report is captured in cases. Where noted, information is also requested in claims. Information on decisions is also requested, as applicable.

Due Date -Transmit the CMS-2592 to CO via PC or terminal. Use instructions in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.

The report is due as soon as possible after the end of the reporting month but no later than the 15th of the month following the end of the reporting month.

COMPLETION OF ITEMS ON FORM CMS-2592

Heading – This form is referenced as form 7 in the CROWD system. Complete the ADD/UPDATE/DELETE criteria screen with the appropriate information such as your ID Number including Business Segment Identifier (BSI), reporting month and calendar year, i.e., 12 2005 for December 2005.

General Information – Completing the Report

Refer to the information below when determining how to count and categorize data for reporting purposes.

Controlling Receipt of Cases - In order to ensure that cases are processed timely, cases shall be date stamped or controlled in some way upon receipt. The date of receipt in all cases is the day the processing contractor received the request in its corporate mailroom. The days elapsed for an individual request are calculated using the number of days starting from the Julian date of case receipt through the Julian date of completion. Include the time required for the response to be mailed to the appellant. For example, a case that is received and processed on January 7 is considered to require1 day to clear. A case received on January 7 and cleared on January 8 is considered to require 2 days to clear. Consider the day of receipt to be Day 1.

Cases that are not received in the mailroom (for example, requests from the QIC for case files received by fax or telephone) shall be controlled in some way to ensure that timeliness requirements are met.

Counting Cases -- If an appellant submits one request involving several different claims (and several different beneficiaries), count it as one case. If the contractor receives one envelope with multiple request forms and supporting documentation, count 1 case per request received. For example, if the envelope contains 10 separate request forms with supporting documentation, count as 10 cases.

Counting Part A, B of A and Part B Claims - If an appellant submits one request involving 5 different claims, count as 5 claims. If an appellant submits one request involving 1 claim, count as 1 claim. If the appellant submits two cases in the same envelope, of which one case has 3 claims and the other 4 claims, count as 2 cases with 7 claims. If an appellant submits a case containing 7 claims, of which 5 are requests for an appeal and the remaining 2 are determined to be reopenings, count the 5 appeal claims among the appeals workload. The remaining 2 claims shall not be counted among the appeals workload, but shall be counted as reopenings (see Line 1 of the Reopenings Section).

Counting Part A, B of A and Part B Cases Involving Appeals and Reopenings – If you receive a case involving multiple claims and some claims are subject to appeal but others must be handled as a reopening, count the case as an appeal. **Note**: Reopenings data is captured by claims only. Because of this, no case count is recorded for reopenings.

Additional Evidence Submitted After Request is Received -- If you receive a case for which additional documentation is submitted for some but not all of the claims, count the case among those recorded on Line 7 (Cleared - Evidence Submitted After Request).

When to Consider a Case Reversed -- Consider a case reversed when the initial determination is changed upon appeal, (e.g., the claim was denied at the initial determination level but is reversed when the case is appealed).

When to Consider a Case Completed – Consider a case to be completed when you complete the action that sets in motion correct payment of the claim, or for intermediaries or the A/B MACs, written assurance from the provider is requested for Part A cases, if applicable **and** you mail the decision letter to the appellant. Both actions shall be completed before you record the case completed for timeliness purposes. All redeterminations shall be processed **and <u>mailed</u>** by the 60th day (unless additional evidence is submitted by the party after the request is received, in which case the contractor has up to 14 additional days for each submission to process and mail the decision letter to the parties.

See Line 6.1 for additional guidance.

When to Consider a Case Effectuated – Consider effectuation of a decision to be completed when payment is issued to the appellant based on a fully favorable or partially favorable decision. If you enter the adjustment in the month of July, but payment is not issued to the appellant until August, the case is considered to be effectuated in August.

In instances where it is necessary for an intermediary to seek written assurance on Part A cases, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs only after such written notice from the provider is received.

Note: Considering a case to be completed is different from determining when a case is effectuated. Please note the distinctions in the previous paragraphs. It is possible for some overlap of completion and effectuation timeframes to occur.

460.2 - Section I – Redeterminations

(Rev. 144; Issued: 11-28-08; Effective Date: 04-01-09; Implementation Date: 04-06-09)

This section concerns data from Part A and Part B of A appeals processed by intermediaries, as well as Part B appeals processed by carriers.

Redeterminations. The number of redeterminations requested (received), completed, and pending reflects the status of the workload as of the last day of the reporting month. Base data on actual counts of each activity and not on sampling or other estimating techniques.

A redetermination is the first level of appeal following an initial determination of a Part A claim or Part B claim. It is a re-evaluation of the facts and findings of a claim to determine whether the initial decision was correct. (See the Medicare Claims Processing Manual, Publication 100-04, Chapter 29, Section 310.)

Do not count duplicate redetermination requests or redetermination requests received before you have made an initial determination on a claim. Do not count inquiries. Count one redetermination per request received. With the exception of those lines for which claims counts are specifically requested in the report, count only cases. Do not count a duplicate request for appeal as a processed appeal. Duplicate requests can be reflected in Line 2 (Adjustment to Pending) of the CMS-2592 Report for the subsequent month.

Redeterminations fall into the following categories:

Column (1) Part A Cases- Use Column 1 to report information on Part A services processed by the intermediary.

Column (2) Part B of A Cases- Use Column 2 to report information on Part B services processed by the intermediary.

Column (3) Part B Cases- Use Column 3 to report information on Part B services processed by the carrier.

Line 1. Opening Pending - Show under columns 1-3, the number of redetermination cases reported on Line 21 as the closing pending redetermination cases on the previous month's report.

Line 2. Adjustments to Pending - CMS understands that it is often necessary to revise the categorization of data from the original categorization given when a case was initially received at the contractor. Likewise, it is often necessary to move data from one line to another in order to maintain accuracy. Prior to the submission of the monthly 2592 report to CMS, contractors are permitted to make changes to data during the reporting month to ensure that appeal workloads are accurately reflected.

Once the monthly 2592 report has been submitted to CMS, any changes to the closing pending figure of the report must be reflected in the Adjustments to Pending line of the subsequent month's report. If it is necessary to revise the pending figure for the close of the **previous** month's report because of inventories or reporting errors, enter the adjustment. If some cases were not counted in the proper month's receipts, count them as adjustments to the opening pending count in the subsequent month. Examples include any instances where something originally categorized as an appeal was determined not to be an appeal, or vice-versa. Duplicate requests for redetermination are also reflected here. If the contractor receives a request for appeal near the end of the reporting month but the case arrives too late to be reflected as a receipt in the CMS-2592 report for that month, count the case in the Adjustment to Pending line of the subsequent month's report. The purpose of the Adjustments to Pending line is to allow the contractor to modify Opening Pending counts, thereby correcting errors resulting from inventory or reporting problems that were identified after the submission of the CMS-2592 previous month's report to CMS.

Do not make adjustments to the Pending line or other lines of the 2592 report once the report has been submitted to CMS. If there is an entry for Line 2, it should be preceded by a "+" or "-", as appropriate.

Line 3. Adjusted Pending - Enter the result of Line 1 + Line 2 (taking into account the "-" sign, if any).

Line 4. Requests Received - Show, under the appropriate columns, the number of requests for redeterminations received during the reporting month. Include requests transferred to you by other intermediaries or carriers or remanded by the Qualified Independent Contractor (QIC).

NOTE: See the "Note" under Line 6 (Requests Cleared) regarding the handling of Medicare Secondary Payer (MSP) cases.

Line 5. Misrouted Requests Forwarded to Another Contractor - Show under columns 1 through 3 the number of redetermination requests the contractor forwarded to other contractors, because they were misrouted to you and you did not process the original claim(s). For columns 1-3, if you have reported a redetermination as forwarded, do not report any information regarding it on Lines 6-29. The forwarding of the misrouted request is the final action.

NOTE: This line is not intended for QIC reconsideration requests that were misrouted.

Line 6. Requests Cleared - Show, under the appropriate columns, the total number of redeterminations completed during the month. Report all completed redeterminations, regardless if the final outcome was an affirmation, reversal, withdrawal, or dismissal. Do not count cases that were transferred to another contractor because they were misrouted.

NOTE: Intermediaries should count received and completed MSP redetermination cases in Columns 1 of Lines 4 and 6, as appropriate, regardless of whether claims involved are Part A, Part B or a combination. Do not count or report claims involved in MSP cases. MSP cases should be counted in Lines 4, 6, 7, 8, 9, 10 and 11. Do not count MSP claims on Lines 6.1, 7.1, 8.1, 9.1, 10.1 and 11.1.

Carriers that handle MSP cases should count them in Column 3.

Line 6.1. Number of Claims Cleared – Show the total number of claims involved in Line 6.

NOTE: For Lines 6.1 through 11.1 (letters a through i), enter the number and type of claim processed. If no claims from a certain claim type are processed, enter NA. Refer to instructions for the CMS-1565 and 1566, as well as appropriate sections of the Claims Processing Manual for guidance on determining the categories and types of claims processed by intermediaries, A/B MACs, carriers DMERCs and DME MACs.
Line 6.1a – Report the number of SNF claims included in Line 6.1. Line 6.1b – Report the number of Home Health claims included in Line 6.1. Line 6.1c – Report the number of Inpatient Hospital claims included in Line 6.1. Line 6.1d – Report the number of Outpatient claims included in Line 6.1. Line 6.1e – Report the number of Lab claims included in Line 6.1. Line 6.1f – Report the number of Ambulance claims included in Line 6.1. Line 6.1g – Report the number of DME claims included in Line 6.1. Line 6.1h – Report the number of Physician claims reported in Line 6.1. Line 6.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 6.1.

Consider a redetermination cleared when:

- For affirmations, when all claims of the case are included in the decision and the decision letter is <u>mailed</u> to the parties

- For full and partial reversals:

  (1) all claims within the case are included in the decision and the decision letter is mailed to the parties, and

  (2) the contractor completes the action that sets in motion correct payment of the claim **or,** for intermediaries, written assurance from the provider for Part A cases is requested, if applicable.

- For withdrawals and dismissals, the dismissal notice is mailed to the parties.

Note that sending a letter to the mailroom does not constitute mailing the letter. Letters must be mailed to the appellant on or before the 60th day in order for the requirement to be met.

NOTE: Considering a case to be completed is different from determining when a case is effectuated. Please note the distinctions in the previous paragraphs.

Line 6.2. Recovery Audit Contractor (RAC) Redeterminations Cleared - Of the cases reported in Line 6, how many are RAC related?

Line 6.2.1. Number of RAC Claims Involved – Show the number of claims involved in Line 6.2.

Line 7. Cleared -- Evidence Submitted After Request - Of the cases reported in Line 6, show under the appropriate columns, the total number of redetermination cases for which additional documentation was submitted by the party on his or her own or when the documentation was requested by the contractor after the request was received.

Line 7.1. Number of Claims Involved – Show the total number of claims involved in Line 6.1 for which evidence was submitted after the request was received.

Lines 7.1a through 7.1i are Not Applicable. Line 7.1a – Report the number of SNF claims included in Line 7.1. Line 7.1b – Report the number of Home Health claims included in Line 7.1. Line 7.1c – Report the number of Inpatient Hospital claims included in Line 7.1. Line 7.1d – Report the number of Outpatient claims included in Line 7.1. Line 7.1e – Report the number of Lab claims included in Line 7.1. Line 7.1f – Report the number of Ambulance claims included in Line 7.1. Line 7.1g – Report the number of DME claims included in Line 7.1. Line 7.1h – Report the number of Physician claims reported in Line 7.1. Line 7.1i - Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 7.1.

Line 7.2. RAC Redeterminations Cleared With Additional Documentation - Of the cases reported in Line 7, how many are RAC related?

Line 7.2.1. Number of RAC Claims Involved – Show the number of claims involved in Line 7.2.

Note about Lines 8-11:

Count the cases in the following manner:

- If a case has multiple claims and all are affirmed, count the case as an affirmation.
- If a case has multiple claims, some of which are affirmed and others are partially reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.
- If a case has multiple claims, some of which are partially reversed and others are fully reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

- If a case has multiple claims, all of which are fully reversed, count the case as a full reversal.

- If a case has multiple claims, some of which are fully reversed and the others are dismissed or withdrawn, count the case as a full reversal.

- If a case has multiple claims, one of which is affirmed, one of which is a partial reversal and one of which is dismissed, count the case as a partial reversal.

- If a case has multiple claims which are fully reversed, affirmations and withdrawals/dismissals, count the case as a partial reversal.

- If a case has two claims, one of which is affirmed and the other is dismissed, count the case as an affirmation.

Full	Partial	Affirmation	Dismissal/ Withdrawal	=	Report As
X					Full
	X				Partial
		X			Affirmation
			X		Dismissal/ Withdrawal
X	X				Partial
X		X			Partial
X			X		Full
X	X	X			Partial
X	X	X	X		Partial
	X	X			Partial
	X		X		Partial
		X	X		Affirmation
	X	X	X		Partial

Line 8. Affirmations - Under the appropriate columns, show the number of completed redeterminations from Line 6 in which the previous determinations were completely upheld; i.e., no change was made. All claims in a case must be upheld in order for the case to be counted as an affirmation. In instances where claims some are affirmed, but all others are dismissed or withdrawn, count the case as an affirmation. (Do not include partial reversals in this line. See Line 9 for partial reversals). Include those instances where the decision was affirmed, but a change in liability was noted.

Line 8a. Waiver of Liability Amount Paid Not Applicable - Show the amount paid under waiver of liability, on the basis that the party did not know that the service wasn't payable under Medicare.

Line 8.1. Number of Claims Affirmed – Show the number of claims involved in Line 6.1 for which the decision was affirmed.

NOTE -- The following example is counted as an affirmation: A claim is denied at the initial determination level and a redetermination is requested. At the redetermination level, the denial is upheld but the denial is for a reason other than was determined to be applicable at the initial determination level. Count the claim as an affirmation.

Line 8.1a – Report the number of SNF claims included in Line 8.1. Line 8.1b – Report the number of Home Health claims included in Line 8.1. Line 8.1c – Report the number of Inpatient Hospital claims included in Line 8.1. Line 8.1d – Report the number of Outpatient claims included in Line 8.1. Line 8.1e – Report the number of Lab claims included in Line 8.1. Line 8.1f – Report the number of Ambulance claims included in Line 8.1. Line 8.1g – Report the number of DME claims included in Line 8.1. Line 8.1h – Report the number of Physician claims reported in Line 8.1. Line 8.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 8.1.

Line 8.2. RAC Redeterminations Affirmed- Of the affirmation cases reported in Line 8, how many are RAC related?

Line 8.2.1. Number of RAC Claims Involved – Show the number of claims involved in Line 8.2.

Line 9. **Partial Reversals** - Under the appropriate columns, show the number of completed redeterminations, from Line 6 in which part of the prior determination decision of the appealed lines was reversed. That is, a change was made and some part of the new determination was in favor of the appellant. **NOTE:** Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

Line 9.1. Number of Claims Partially Reversed – Show the number of claims involved in Line 6.1 for which the decision is partially reversed. Note: It is possible to have zero claims in Line 9.1, even when cases are recorded in Line 9.

Line 9.1a – Report the number of SNF claims included in Line 9.1. Line 9.1b – Report the number of Home Health claims included in Line 9.1. Line 9.1c – Report the number of Inpatient Hospital claims included in Line 9.1. Line 9.1d – Report the number of Outpatient claims included in Line 9.1. Line 9.1e – Report the number of Lab claims included in Line 9.1. Line 9.1f – Report the number of Ambulance claims included in Line 9.1. Line 9.1g – Report the number of DME claims included in Line 9.1. Line 9.1h – Report the number of Physician claims reported in Line 9.1. Line 9.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 9.1.

Line 9.2. RAC Redeterminations Partially Reversed– Of the partially reversed cases reported in Line 9, how many are RAC related?

Line 9.2.1 Number of RAC Claims Involved – Show the number of claims involved in Line 9.2.

Line 10. Full Reversals - Under the appropriate columns, show the total number of completed redeterminations from Line 6 in which the previous determination decision of the appealed lines was completely reversed. **NOTE:** Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

Line 10.1. Number of Claims Fully Reversed – Show the number of claims involved in Line 6.1 for which the decision is fully reversed.

Line 10.1a – Report the number of SNF claims included in Line 10.1. Line 10.1b – Report the number of Home Health claims included in Line 10.1. Line 10.1c – Report the number of Inpatient Hospital claims included in Line 10.1. Line 10.1d – Report the number of Outpatient claims included in Line 10.1. Line 10.1e – Report the number of Lab claims included in Line 10.1. Line 10.1f – Report the number of Ambulance claims included in Line 10.1. Line 10.1g – Report the number of DME claims included in Line 10.1. Line 10.1h – Report the number of Physician claims reported in Line 10.1. Line 10.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 10.1.

Line 10.2 RAC Redeterminations Fully Reversed – Of the fully reversed cases reported in Line 10, how many are RAC related?

Line 10.2.1 Number of RAC Claims Involved – Show the number of claims involved in Line 10.2.

Line 11. Dismissals/Withdrawals - Report, under the appropriate column, the number of cases from Line 6 that were withdrawn by the appellant or dismissed (before determination) by you. In order for a case to be recorded in Line 11, all claims in the case must be dismissed or withdrawn.

NOTE: Do not count cases that were dismissed because they were determined to be incomplete in Line 11. Cases that were dismissed because they were determined to be incomplete should only be counted in Line 12.

Line 11.1. Number of Claims Dismissed or Withdrawn – Show the number of claims involved in Line 6.1 which were dismissed or withdrawn.

Line 11.1a – Report the number of SNF claims included in Line 11.1. Line 11.1b – Report the number of Home Health claims included in Line 11.1. Line 11.1c – Report the number of Inpatient Hospital claims included in Line 11.1. Line 11.1d – Report the number of Outpatient claims included in Line 11.1. Line 11.1e – Report the number of Lab claims included in Line 11.1. Line 11.1f – Report the number of Ambulance claims included in Line 11.1. Line 11.1g – Report the number of DME claims included in Line 11.1. Line 11.1h – Report the number of Physician claims reported in Line 11.1. Line 11.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 11.1.

Notes:

Misrouted correspondence and duplicate requests are not dismissals.

Line 11.2. RAC Redeterminations Dismissed or Withdrawn - Of the dismissed or withdrawn cases reported in Line 11, how many are RAC related?

Line 11.2.1. Number of RAC Claims Involved – Show the number of claims involved in Line 11.2.

Line 12. Number of Incomplete Redetermination Requests Dismissed - Enter the number of cases that were dismissed because the request was incomplete. Report incomplete cases in Line 12 only if ALL the claims from the case are incomplete. For information on what constitutes an incomplete request, refer to the Medicare Claims Processing Manual, Publication 100-04; Chapter 29; Section 310.1

> **NOTE:** If one redetermination request contains multiple claims and or line items and is split, report the case according to the overall disposition of the individual claims and/or line items. (In many instances, split cases will be reported as partially reversed).
>
> **Example:** A supplier submits a redetermination request that contains one request with 50 claims involving different beneficiaries. The request contains a name and signature of the appellant/supplier, and the supporting documentation identifies individual claims of the beneficiaries, pertinent HIC numbers and the dates of service. However, for some of the claims, the supplier does not identify the specific services (among the several line items on the claim) that are disputed. The contractor should not dismiss the entire redetermination request. Rather, in this situation, the contractor issues dismissals (incomplete requests) with respect to the individual claims for which the requisite information is incomplete, and issues favorable and/or unfavorable decisions for the remaining claims, as appropriate. For the purposes of reporting, the case is reported according to the overall disposition of the individual claims and/or line items. If the case contains some affirmations, reversals and dismissals, count the case as partially reversed in Line 9.
>
> **Example:** A supplier submits a redetermination request that contains one request with 50 claims involving different beneficiaries. The request is missing the signature of the appellant/supplier, but identifies the individual claims of the beneficiaries, pertinent names and HIC numbers, dates of service and the items or services disputed. Since the signature is missing, the entire request would be dismissed as incomplete, and counted in Line 12 of the CMS-2592.
>
> Do not count cases that were dismissed for reasons other than being incomplete on Line 12. Only count those instances for which the entire request is dismissed on Line 12.

Line 13. Medicare Approved Amount (Not Applicable) - For cases included in Lines 9 and 10, show the Medicare Approved Amount for services where the initial determination was reversed at the redetermination level, either fully (Line 10) or partially (Line 9). Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

Processing and Pending Times -This deals with processing and pending times for Part A and Part B appeals.

Computing Time to Process Redeterminations for (Lines 6 through 25)

For Lines 6-25, use the matrix below to determine the number of days from receipt to completion of redeterminations. The date of receipt in all cases is the day the processing contractor received the request in its corporate mailroom. In order to ensure that cases are processed timely, cases should also be date stamped or controlled in some way in the mailroom.

Situation	Date Completed
o The appellant withdraws the request.	The date the dismissal letter is mailed to the party.
o The contractor dismisses the request	The date the dismissal letter is mailed to the party.
o The contractor reverses the initial determination.	For both full and partial reversals, when the contractor completes the action that sets in motion correct payment of the claim and the contractor mails the decision letter to the party.
o The contractor affirms the initial determination	The date the decision letter is mailed to the party.

REDETERMINATIONS

PROCESSING TIME: REDETERMINATIONS WITH DOCUMENTATION SUBMITTED TIMELY (Lines 14-16)

Line 14. Redetermination Processing Time – Average – Report, under the appropriate columns, the average number of days from receipt of the redetermination in the corporate mailroom to the date of completion. Do not include redeterminations where documentation is submitted after the request (i.e., a redetermination cannot be counted in both Line 14 and Line 17).

To compute the average number of days from request to completion, divide the total days elapsed for all requests (where the documentation was submitted timely) cleared in the month by the number of requests cleared. Round results to the nearest day. The days elapsed for an individual request are calculated using the number of days from the Julian date of case receipt through the Julian date of completion. Include the time required for the response to be mailed to the appellant. If the request is cleared in the year following the year of receipt, add 365 or 366 to the result, as appropriate. (Otherwise, you will get a negative number). If a case is cleared the same day it is received, consider it to require one day. For example, a case that is received and processed on January 7 is considered to require one day to clear. A case received on January 7 and cleared on January 8 is considered to require 2 days to clear.

Include all cases cleared, regardless of whether they were affirmed, reversed, dismissed, or withdrawn.

Line 15. Redeterminations Completed in 1-60 Days - Show the number of redeterminations that required 1-60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom). Do not include redeterminations reported in Lines 18-20.

Line 15a. RAC Redeterminations Completed in 1-60 Days – Of the total number of appeals reported in Line 15, show the number that are RAC related.

Line 16. Redeterminations Completed in over 60 Days - Show the number of redeterminations that required more than 60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom). Do not include redeterminations reported in Lines 18-20.

Line 16a. RAC Redeterminations Completed in Over 60 Days – Of the number of appeals reported in Line 16, show the number that are RAC related.

PROCESSING TIME: Redeterminations with DOCUMENTATION SUBMITTED AFTER REQUEST WAS RECEIVED (Lines 17-20)

NOTE: This section captures information in instances where the party submits additional documentation at the redetermination level (including those instances when the contractor requests the additional documentation) after the initial request for redetermination is received. The contractor must receive the documentation before the 60 day timeframe is up in order for data to be entered into Lines 17-20.

Line 17. **Redeterminations Processing Time - Average (Documentation Submitted Later)** – For redeterminations where documentation/evidence is submitted after the request is received, report under the appropriate columns, the average number of days from receipt of the redetermination to the date of completion. Using redeterminations where documentation was submitted later as the basis, follow instructions in Line 14 to calculate the average processing time.

Line 18. Redeterminations Completed in 1-60 Days (Documentation Submitted Later) - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 1-60 calendar days were required to complete the case.

Line 18a. RAC Redeterminations Completed in 1-60 Days (Documentation Submitted Later) – Of the number of appeals reported in Line 18, show the number that are RAC related.

Line 19. Redeterminations Completed in 61-74 Days (Documentation Submitted Later) - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 61-74 calendar days were required to complete the case.

Line 19a. RAC Redeterminations Completed in 61-74 Days (Documentation Submitted Later) – Of the number of appeals reported in Line 19, show the number that are RAC related.

Line 20. Redeterminations Completed in over 74 Days (Documentation Submitted Later) - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and more than 74 calendar days were required to complete the case.

Line 20a. RAC Redeterminations Completed in over 74 Days (Documentation Submitted Later) – Of the number of appeals reported in Line 20, show the number that are RAC related.

Pending Time Frames

Line 21. Closing Pending Redeterminations - Show, under the appropriate columns, the total number of redeterminations that have not been completed by the end of the reporting month. Note: Do not include pending effectuations in this line.

Line 22. Redeterminations Pending 1-30 Days – Show the number of redeterminations included in Line 21 that have been pending for 1-30 days, inclusive, at the end of the reporting month.

Line 23. Redeterminations Pending 31-60 Days - Show the number of redeterminations included in Line 21 that have been pending 31-60 days, inclusive, at the end of the reporting month.

Line 24. Redeterminations Pending 61-74 Days - Show the number of redeterminations included in Line 21 which have been pending 61-74 days, inclusive at the end of the reporting month.

Line 25. Redeterminations Pending Over 74 Days - Show the number of redeterminations included in Line 21 which have been pending more than 74 days at the end of the reporting month.

EFFECTUATION OF REDETERMINATION DECISIONS

Line 26. Total Effectuations - Show the number of redetermination cases for which you effectuated a decision during the month. Consider effectuation of a decision to be completed when you issue payment to the appellant based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue. Do not include cases for which no effectuation is required.

Notes: Considering a case to be completed is different from determining when a case is effectuated. Please refer to the distinctions in the introductory sections of the2592 report ("When to Consider a Case Completed" and "When to Consider a Case Effectuated").

In instances where it is necessary for an intermediary to seek written assurance for Part A cases, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs only after such written notice from the provider is received.

Line 26a. Number of Claims Involved – Show the number of claims involved in Line 26.

Line 27. Number Effectuated 1-30 Days - Show the number of claims from Line 26a where you effectuated the decision within 30 calendar days of the date of the decision.

Line 28. Number Effectuated 31-60 Days - Show the number of claims from Line 26a where you effectuated the decision within 31- 60 calendar days of the date of the decision.

Line 29. Number Effectuated Over 60 Days - Show the number of claims from Line 26a where you effectuated the decision in more than 60 calendar days of the date of the decision.

460.3 - Section II - Qualified Independent Contractor (QIC) Reconsiderations

(Rev. 144; Issued: 11-28-08; Effective Date: 04-01-09; Implementation Date: 04-06-09)

- Use Section II to report requests for reconsideration.

Reconsiderations, the second level of appeal, are processed by the QIC. This section of the report captures information related to several distinct pieces associated with the reconsideration process. While requests for reconsideration should be sent directly by the appellant to the QIC, it is probable that some requests will be sent to intermediaries, A/B MACs, carriers and DME MACs, requiring the need for forwarding the request, and the associated case file, to the QIC. In those instances where the requests for reconsideration are sent directly to the QIC as required, the QICs will have to request case file information from the contractor before the reconsideration can be conducted. In addition, the contractor will effectuate QIC decisions, as appropriate.

QIC RECONSIDERATIONS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) Part A Cases- Use Column 1 to record information on reconsiderations of redeterminations for Part A services processed by the intermediary.

Column (2) Part B of A Cases Use Column 2 to record information on reconsiderations of redeterminations for Part B services processed by the intermediary.

Column (3) Part B Cases- Use Column 3 to record information on reconsiderations of redeterminations for Part B services processed by the carrier.

Line 30. Opening Pending - Show the number of closing pending reconsiderations reported on Line 47 on the previous month's report.

Line 31. Adjustments to Pending - If it is necessary to revise the pending figure for the close of the previous month because of inventories or reporting errors, enter the adjustment. Report requests received near the end of the reporting month and placed under control in the subsequent month as received in the reporting month, not as requests received in the subsequent month. If some cases were not counted in the proper month's receipts, count them as adjustments to the opening pending in the subsequent month.

Line 32. Adjusted Opening Pending - Show the result of Line 30 + Line 31 (taking into account the "-" sign, if any).

Line 33. Requests for QIC Reconsideration Received by the Contractor - Show the number of QIC reconsiderations received by the contractor during the month. Although the requests for reconsideration should be sent directly to the QIC, some requests may be sent directly to the contractor in error, and as such, are considered to be "misrouted". Enter the number reconsideration requests sent by the appellant or their representative directly to the contractor. The contractor must forward these requests, along with the associated case file, to the QIC.

Line 33a. Misrouted Requests Forwarded to QIC –Show the number of misrouted reconsideration requests that were forwarded to the QIC, along with the associated case file, during the month. Do not include duplicate requests for reconsideration in this line.

Line 33b. Misrouted Requests Forwarded Timely – Of the number reflected in Line 33a, show the number forwarded to the QIC in 1-30 calendar days.

Line 33c. Misrouted Requests Forwarded Untimely – Of the number reflected in Line 33a, show the number forwarded to the QIC in more than 30 calendar days.

Line 34. Requests from QIC for Case Files: Upon receipt of the request for reconsideration, the QIC must contact the contractor to request the case file. Show the number of requests for case files received by the contractor from the QIC during the month. Requests can be received in the corporate mailroom, by telephone or by fax. Consider the date of receipt as the date you receive the QIC request for the case file.

Line 35. Number of Case Files Forwarded to QIC - Show the number of reconsideration case files forwarded to QICs during the month. Consider the case forwarded when all necessary material has been mailed to the QIC.

Line 36. Number Forwarded in 1-5 Days – Show the number of Reconsideration case files forwarded to the QIC in 1-5 calendar days from the date of receipt of the QIC request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.

Line 36a. Number Forwarded In 6 Days - Show the number of Reconsideration case files forwarded to the QICs in 6 calendar days from the date of receipt of the QIC request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.

Line 37. Number Forwarded In 7-8 Days - Show the number of Reconsideration case files forwarded to the QICs in 7-8 calendar days from the date of receipt of the QIC request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.

Line 37a. Number Forwarded In Over 8 Days - Show the number of Reconsideration case files forwarded to QICs in over 8 calendar days from the date of receipt of the QIC request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.

Line 38. Average Time to Forward - The average number of calendar days from date of the QIC request to the date you mail the necessary information. Refer to instructions contained in Line 14 to determine average time to forward.

Line 39. Pending Case File Requests – Show the number of case files yet to be forwarded to the QIC. This could include requests received from, but not yet sent to the QIC, as well as those reconsideration requests sent to the contractor instead of the QIC.

Disposition of QIC Decisions

Line 40. Number of QIC Decisions Received From QIC- Show the number of Reconsideration requests completed by the QIC and returned to the contractor during the month.

Line 41. Number of QIC Decisions That Need Effectuation - Show the number of Reconsideration decisions from Line 40 which must be effectuated.

41a. Number of Claims Involved: Show the number of claims involved in Line 41.

EFFECTUATION OF QIC DECISIONS

Line 42. Total Effectuations - Show the number of Reconsideration decisions for which you effectuated a decision during the month. Consider effectuation of a decision to be completed when you issue payment to the appellant based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue. Do not include cases for which no effectuation is required.

NOTE: Considering a case to be completed is different from determining when a case is effectuated. Please refer to the distinctions in the introductory sections of the2592 report ("When to Consider a Case Completed," and "When to Consider a Case Effectuated").

NOTE: If the QIC's decision is favorable to the appellant and gives a specific amount to be paid, effectuation must occur within 30 calendar days of the date of the QIC's decision. If the decision is favorable but the amount to be paid must be computed, effectuation must occur within 30 days after the amount is computed. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the QIC's decision.

NOTE: In instances where it is necessary for an intermediary or A MAC to seek written assurance for Part A cases, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs within 30 days after such written notice from the provider is received.

Line 42a. Number of Claims Involved – Show the number of claims involved in Line 42.

NOTE: Information captured in Lines 43, 44 and 45 reflects time to compute the amount to be paid as well as the effectuation timeframes. Information provided in Lines 43-45 also assumes that contractors must calculate the amounts to be paid. Even though all appropriate timeframes are not reflected here, contractors are still required to follow applicable manual requirements and timeframes with regard to receipt, calculation and effectuation of decisions. CMS anticipates that effectuation of most decisions for which the amount is provided should fall into Line 43.

Line 43. Number Effectuated in 1-30 Days - Show the number of claims from Line 42a where you effectuated the decision within 30 calendar days. Effectuation days include the day of receipt of the reconsideration effectuation notice in your corporate mailroom or electronic transmission, such as fax or secure e-mail through the day the payment is issued. Include written assurance cases in this line, as applicable.

43a. Contractor Computed Amount – Of the number reflected on Line 43, show the number where the contractor was required to compute the amount to be paid. An entry of zero indicates that the contractor was not required to compute the amount for any claim.

Line 44. Number Effectuated in 31-60 Days - Show the number of claims from Line 42a where you effectuated the decision within 31-60 calendar days. Effectuation days include the day of receipt of the reconsideration effectuation notice in your corporate mailroom or electronic transmission, such as fax or secure e-mail through the day the payment is issued. Include written assurance cases in this line, as applicable.

44a. Contractor Computed Amount – Of the number reflected on Line 44, show the number where the contractor was required to compute the amount to be paid. An entry of zero indicates that the contractor was not required to compute the amount for any claim.

Line 45. Number Effectuated in Over 60 Days - Show the number of claims from Line 42a where you effectuated the decision in more than 60 calendar days. Effectuation days include the day of receipt of the reconsideration effectuation notice in your corporate mailroom or electronic transmission, such as fax or secure e-mail through the day the payment is issued. Include written assurance cases in this line, as applicable.

45a. Contractor Computed Amount – Of the number reflected on Line 45, show the number where the contractor was required to compute the amount to be paid. An entry of zero indicates that the contractor was not required to compute the amount for any claim.

Line 46. Medicare Approved Amount (Not Applicable) - For decisions included in Line 42 show the Medicare approved amount for services at the QIC level where the determination was reversed, either fully or partially. Show the charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

It is preferable to report the Medicare Approved Amount at the time that cases are reported on line 42. However, CMS will consider it acceptable for contractors to report the Medicare Approved Amount when adjustment claims tied to cases that are reporting or will report to line 42 finalize.

Line 46a. Waiver of Liability Amount Paid (Not Applicable) – Of the amount recorded on Line 46, show the amount applicable to a waiver of liability payment on the basis that the party did not know that the service wasn't payable under Medicare.

Line 47. Closing Pending Reconsiderations - Show the total number of reconsideration requests that were not effectuated by the end of the reporting month. Consider a case pending from the date of receipt of the request at the contractor, or the date of the request for the case file from the QIC, until you have received the completed decision from the QIC for all parts of the case. This number shall also reflect those case files not yet forwarded to the QIC by the contractor as well as those decisions that have been received by the contractor from the QIC that still require effectuation on the part of the contractor. For example, if you receive a case from the QIC, and have initiated the adjustment into the system, but have not issued the payment, the case is reported in Line 47 as pending.

Do not include instances where a misrouted file has been sent to the proper QIC in another jurisdiction. Misrouted files that belong to a QIC in another jurisdiction should be considered closed once they have been forwarded to the appropriate QIC. Files that are forwarded to the QIC servicing the same jurisdiction as the contractor should remain open until the effectuation is complete.

460.4 – Section III- Administrative Law Judge Results

(Rev. 144; Issued: 11-28-08; Effective Date: 04-01-09; Implementation Date: 04-06-09)

Line 48. Opening Pending - Show the number of ALJ decisions reported on Line 57 as the closing pending on the previous month's report.

Line 49. Number of Appeal Requests for ALJ Hearing Misrouted to Contractor – Report the number of appeal requests for an ALJ hearing that were misrouted to the contractor when they should have been filed with the Office of Medicare Hearings and Appeals instead. These are ALJ requests that were filed with the contractor by mistake.

Line 50. Number of ALJ Decisions Received From Administrative QIC (AdQIC) - Show the number of ALJ hearing decisions returned by the AdQIC to the contractor during the month. Consider the receipt date to be the date the case is received from the AdQIC. Include instances where decisions were received in the previous month, but were not entered into the system until the current month.

Line 51. Number of ALJ Decisions Received that Need Effectuation - Show the number of ALJ decisions from Line 50 which must be effectuated.

Line 51a. **Number of Claims Involved –** Show the number of claims involved in Line 51.

Line 52. Total Effectuations -Show the number of ALJ decisions effectuated during the month. Consider effectuation of a decision to occur when you issue payment based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue. Do not include cases for which no effectuation is required.

NOTE: In instances where it is necessary for an intermediary or A MAC to seek written assurance for Part A cases, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary’s behalf, has been refunded. Payment occurs within 30 days after such written notice from the provider is received.

Line 52a. Number of Claims Involved – Show the number of claims involved in Line 52.

NOTE: Information captured in Lines 53, 54 and 55 assumes that contractors must calculate the amounts to be paid before effectuation can occur. Contractors are required to follow other applicable timeframes used when specific amounts to be paid have been provided with the information received from the AdQIC. CMS anticipates that effectuation of most decisions for which the amount is provided should fall into Line 53.

Line 53. Number Effectuated in 1 - 30 Days - Show the number of claims from Line 52a where you effectuated the decision within 30 calendar days. Effectuation days include day of receipt of the effectuation notice from the AdQIC in your corporate mailroom or electronic transmission, such as fax or secure e-mail, through the day the payment is issued.

Line 54. Number Effectuated in 31 - 60 Days - Show the number of claims from Line 52a where you effectuated the decision within 31-60 calendar days. Effectuation days include day of receipt of the effectuation notice from the AdQIC in your corporate mailroom or electronic transmission, such as fax or secure e-mail, through the day the payment is issued.

Line 55. Number Effectuated in Over 60 Days - Show the number of claims from Line 52a where you effectuated the decision in more than 60 calendar days. Effectuation days include day of receipt of the effectuation notice from the AdQIC in your corporate mailroom or electronic transmission, such as fax or secure e-mail, through the day the payment is issued.

Line 56. Medicare Approved Amount (Not Applicable) - For decisions included in Line 52, show the Medicare approved amount for services where the reconsideration determination was reversed at the ALJ level, either fully or partially. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

It is preferable to report the Medicare approved amount at the time that cases are reported on line 52. However, CMS will consider it acceptable for contractors to report the Amount Paid when adjustment claims tied to cases that are reporting or will report to line 52 finalize.

Line 56a. Waiver of Liability Amount Paid (Not Applicable) – Of the amount recorded on Line 56, show the amount applicable to a waiver of liability payment on the basis that the party did not know that the service wasn't payable under Medicare.

Line 57. Closing Pending ALJ Decisions - Show the total number of ALJ decisions that were received from the AdQIC, but were not completed by the contractor at the end of the reporting month, and as such, are still pending effectuation. All claims associated with the decision must be received from the AdQIC in order for the decision to be considered complete.

460.5 - Section IV – Medicare Appeals Council Effectuations
(Rev. 130, Issued: 08-31-07, Effective: 01-01-08, Implementation: 01-07-08)

Line 58. Medicare Appeals Council Effectuations – Show the total number of cases received from the Medicare Appeals Council which require effectuation by the contractor. While it is acknowledged that contractors will not have responsibility for forwarding these cases to the Medicare Appeals Council, information is requested since the contractor will have ultimate responsibility to make payment. For reporting purposes, the contractor shall consider the date of receipt as the date the Medicare Appeals Council case is received from the AdQIC.

460.6 - Clerical Error Reopenings
(Rev. 144; Issued: 11-28-08; Effective Date: 04-01-09; Implementation Date: 04-06-09)

When a determination is made on a claim for services, the beneficiary (and the provider, physician or other supplier of medical services) should be able to rely on the fact that the coverage decision and payment amount are correct. Occasionally, information disclosing an error (on the part of the appellant or the contractor) in the determination comes to light after the payment has been incorrectly processed. Regulations do not permit unrestricted reopening of determinations and decisions, but rather, set specific circumstances under which a determination or decision may be reopened. Refer to 42 Code of Final Regulations (CFR) 405.980-986, Interim Final Rule, dated March 8, 2005.The Clerical Error Reopening section of the 2592 report focuses primarily on those clerical error and minor omission reopenings that occur at the pre and post redetermination level. Data on requests at the QIC level and above are only captured in Lines13 and 14 of the Clerical Error Reopening section of the report. Requests for a clerical error reopening may be received in writing or by telephone. Contractors shall continue to use the appropriate columns and lines of the CMS-2591 and CMS-2590 reports to capture data on reopenings that are not clerical in nature. Do not capture clerical error reopenings data on the 2590/2591.

NOTE: **Clerical Error Reopenings data requested in this section should be reported in claims, not cases.**

Line 1. Total Number of Clerical Error Reopenings Received – Show the total number of clerical error reopening requests received during the month. This number includes any requests originally categorized as a reopening at the pre or post-redetermination level, as well as those requests that were originally categorized as an appeal, but were later determined to be a clerical error reopening.

Line 2. Total Number of Clerical Error Reopenings Processed -- Show the total number of clerical error reopenings processed by the contractor during the month.

Line 3. Total Number Processed – Own Motion – Of the number reflected on Line 2, show the number the contractor reopened the claim on their own motion.

Line 4. Total Number Processed – Claimant Initiated – Of the number reflected on Line 2, show the number of reopenings initiated by the claimant.

Line 5. Total Number of Clerical Error Reopenings Resulting From Contractor Error -- Of the reopenings reflected in Line 2, show the total number of claims that were the result of contractor error, whether discovered by the contractor or the claimant.

Line 6. Total Number of Clerical Error Reopenings Resulting From Provider Error -- Of the reopenings reflected in Line 2, show the total number of claims that were the result of provider error, whether discovered by the contractor or the claimant.

NOTE: Particularly with regard to Lines 3 through 6, it is possible for the same claim to be reflected on more than one line.

Line 7: Reserved for Future Use

Line 8: Reserved for Future Use

Line 9. Medicare Approved Amount (Not Applicable) – For cases included on Line 2, show the amount paid for services where the determination was reversed either fully or partially. This is the amount sent after the reopening has been completed – the check amount. Round results to the nearest dollar.

NOTE: Time frames noted in Lines 10, 11 and 11a are for clerical error reopenings initiated by the party only. The time frames do not apply to contractor initiated reopenings or mass adjustments. In addition, no time frames have been established for other types of reopenings.

Line 10. Clerical Error Reopenings Processed in 1-30 Days – Show the number of clerical error reopenings from Line 2 processed in 1-30 calendar days. The processing time frame starts from the date of receipt of the request in the contractor's mailroom.

Line 11. Clerical Error Reopenings Processed in 31-60 Days - Show the number of clerical error reopenings from Line 2 processed in 31-60 calendar days. The processing time frame starts from the date of receipt of the request in the contractor's mailroom.

Line 11a. Clerical Error Reopenings Processed in More than 60 Days – Show the number of clerical error reopenings from Line 2 processed in 61 days or more. The processing time frame starts from the date of receipt of the request in the contractor's mailroom.

Line 12. Total Number of Clerical Error Reopening Requests Pending –Show the number of clerical error reopenings pending at the close of the reporting month.

Line 13. Total Number of Higher Level Reopenings Requiring Adjustment by the Contractor – Show the number of claims that were reopened by the QIC, ALJ or Medicare Appeals Council that require an adjustment by the contractor. These are claims for which the contractor must effectuate the claim as a result of the reopening decision at the higher level.

Line 14. Amount Awarded (Not Applicable) – Show the amount approved for services from Line 13 where the determination was reversed, either fully or partially. Show amounts that are sent to the provider. Round results to the nearest dollar.

It is preferable to report the Medicare Approved Amount at the time that cases are reported on line 13. However, CMS will consider it acceptable for contractors to report the Medicare Approved Amount when adjustment claims tied to cases that are reporting or will report to line 13 finalize.

460.7 - Validation of Reports

(Rev. 144; Issued: 11-28-08; Effective Date: 04-01-09; Implementation Date: 04-06-09)

The SSM shall automatically produce the CMS-2592 carrier appeals validation report and the carrier performance validation report on a daily and monthly basis without specific carrier maintenance or request or without carrier intervention.

Before sending the reports to CMS, **check for completeness and arithmetical accuracy**. Note that the information provided below is applicable to each separate column. Use the following checklist for an arithmetical check for each column:

- Line 1 equals Line 21 from previous month's report.
- For each column, Line 1 plus Line 2 equals Line 3.
- Line 3 plus Line 4 minus Line 5 minus Line 6 minus line 12 equals Line 21 for each column.
- The total of Line 6.1a through 6.1i equals Line 6.1.
- The total of Line 7.1a through 7.1i equals Line 7.1. (Not Applicable)
- The total of Line 8.1a through 8.1i equals Line 8.1.
- The total of Line 9.1a through 9.1i equals Line 9.1.
- The total of Line 10.1a through 10.1i equals Line 10.1.

- The total of Line 11.1a through 11.1i equals Line 11.1.
- Line 6.1 is equal to or greater than Line 6.
- Line 7.1 is equal to or greater than Line 7.
- Line 8.1 is equal to or greater than Line 8.
- Line 10.1 is equal to or greater than Line 10.
- Line 11.1 is equal to or greater than Line 11.

  NOTE: For contractors handling MSP claims, totals for Lines 6.1 through 11.1 may or may not be equal or greater to Lines 6 through 11, respectively.
- Line 8 plus Line 9 plus Line 10 plus Line 11 must equal Line 6.
- Line 8.2 plus Line 9.2 plus Line 10.2 plus Line 11.2 must equal Line 6.2.
- Line 15 plus Line 16 plus Line 18 plus Line 19 plus Line 20 equals Line 6.
- Line 15a plus Line 16a plus Line 18a plus Line 19a plus Line 20a equals Line 6.2.
- Line 22 plus Line 23 plus Line 24 plus Line 25 equals Line 21.
- Line 27 plus Line 28 plus Line 29 equals Line 26a.
- Line 30 equals Line 47 of the previous month’s report.
- Line 30 plus Line 31 equals Line 32.
- Line 33b must not exceed Line 33a.
- Line 33c must not exceed Line 33a.
- Line 33b plus 33c must equal Line 33a.
- Line 36 plus Line 36a plus 37 plus Line 37a equals Line 35.
- Line 41a is equal to or greater than Line 41.
- Line 42a is equal to or greater than Line 42.
- Line 43 plus Line 44 plus Line 45 equals Line 42a.
- Line 46a must not exceed Line 46 (Not Applicable)
- Line 48 plus Line 51 minus Line 52 equals Line 57.
- Line 48 equals Line 57 from the previous month’s report.
- Line 51a is equal to or greater than Line 51.
- Line 52a is equal to or greater than Line 52.
- Line 56a must not exceed Line 56. (Not Applicable)
- Line 53 plus Line 54 plus Line 55 equals Line 52a.
- Line 3 (Reopenings) plus Line 4 (Reopenings) equals Line 2 (Reopenings).
- Line 5 (Reopenings) must not exceed Line 2 (Reopenings).
- Line 5 (Reopenings) plus Line 6 (Reopenings) equals Line 2 (Reopenings)

- Line 6 (Reopenings) must not exceed Line 2 (Reopenings).
- Line 10 (Reopenings) plus Line 11 (Reopenings) plus Line 11a must not exceed Line 4 (Reopenings).

470 - Completing the CMS Quarterly Opt Out Report - General

(Rev. 155; Issued: 07-31-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The contractors prepare and submit to CMS a quarterly report on information regarding the number of physicians and non-physician practitioners (NPPs) who have newly opted out of the Medicare program during the quarter (See The Medicare Benefit Policy Manual, Publication 100-02 Chapter 15, Sec. 40.4). Each contractor shall complete CROWD Form 8 for every state in its jurisdiction. Contractors shall also enter the total number of providers that it has on file, flagged or identified as opt outs (as of the close of the calendar quarter).

The contractor does not submit a hard copy, faxed copy or e-mail version of this report to CMS

470.1 - Due Date

(Rev. 155; Issued: 07-31-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The information shall be entered into CROWD no later than the 30th day following the close of the quarter.

470.2 - Heading

(Rev. 155; Issued: 07-31-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

This report is referenced as Form 8 in the CROWD system. The contractor completes the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to its screen.

470.3 - Definitions of Columns One Through Five

(Rev. 155; Issued: 07-31-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

Physician Specialty Code – A count of the number of physicians in the specified 2 digit code (e.g. 02 = general surgery) that have newly opted out during the quarter.

Column 1- Physician/Non-Physician Practitioner Opt Out Counts – A count of the number of physicians and non-physician practitioners for the specialty code that have opted out during the 1st month of the current quarter.

Column 2- Physician/Non-Physician Practitioner Opt Out Counts - A count of the number of physicians and non-physician practitioners for the specialty code that have opted out during the 2nd month of the current quarter.

Column 3 - Physician/Non-Physician Practitioner Opt Out Counts – A count of the number of physicians and non-physician practitioners for the specialty code that have opted out during the 3rd month of the current quarter.

Column 4 -Total Number of Physicians and Non-Physician Practitioners for a Given Specialty – A total count of physicians and non-physician practitioners for the specialty code in months one, two and three.

Column 5- Physicians/Non-Physician Practitioners on File - A total count of the number of physicians and non-physician practitioners that have opted out status for the specialty code that the contractor has identified in its system as of the end of the quarter.

470.4 - Definitions of Provider Specialty Codes for Opt Out Reporting

(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

The carrier/*A/B MAC* counts individual providers by the specialties listed below. The contractor does not count an individual more than once, even if the individual practices in more than one setting. The specialties specific to opt outs are listed below.

Carrier/*A/B MAC*

General Practice - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 01.

General Surgery - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 02.

Allergy/Immunology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 03.

Otolaryngology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 04.

Anesthesiology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 05.

Cardiology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 06.

Dermatology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 07.

Family Practice - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 08.

Interventional Pain Management - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 09.

Gastroenterology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 10.

Internal Medicine - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 11.

Osteopathic Manipulative Medicine - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 12.

Neurology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 13.

Neurosurgery - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 14.

Obstetrics/Gynecology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 16.

Hospice & Palliative Care - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 17.

Ophthalmology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 18.

Oral Surgery (Dentists Only) - The carrier/*A/B MAC* enters in the appropriate column all dentists with specialty code 19.

Orthopedic Surgery - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 20.

Cardiac Electrophysiology - *The carrier/A/B MAC enters in the appropriate column all physicians with specialty code 21.*

Pathology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 22.

Sports Medicine - *The carrier/A/B MAC enters in the appropriate column all physicians with specialty code 23.*

Plastic and Reconstructive Therapy - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 24.

Physical Medicine and Rehabilitation - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 25.

Psychiatry - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 26.

Geriatric Psychiatry - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 27.

Colorectal Surgery (Formerly Proctology) - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 28.

Pulmonary Disease - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 29.

Diagnostic Radiology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 30.

Anesthesiologist Assistants - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 32.

Thoracic Surgery - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 33.

Urology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 34.

Nuclear Medicine - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 36.

Pediatric Medicine - The carrier/*A/B MAC* MAC enters in the appropriate column all physicians with specialty code 37.

Geriatric Medicine - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 38.

Nephrology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 39.

Hand Surgery - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 40.

Optometry - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 41.

Certified Nurse Midwife - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 42.

Certified registered Nurse Anesthetist (CRNA) Anesthesia Assistant - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 43.

Infectious Disease - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 44.

Endocrinology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 46.

Podiatry - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 48.

Nurse Practitioner - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 50.

Clinical Psychologist (Independent) - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 62.

Rheumatology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 66.

Clinical Psychologist - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 68.

Registered Dietitian/Nutrition Professional - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 71.

Pain Management - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 72.

Peripheral Vascular Disease - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 76.

Vascular Surgery - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 77.

Cardiac Surgery - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 78.

Addiction Medicine - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 79.

Licensed Clinical Social Worker - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 80.

Critical Care (Intensivist) - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 81.

Hematology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 82.

Hematology/Oncology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 83.

Preventative Medicine - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 84.

Maxillofacial Surgery - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 85.

Neuropsychiatry - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 86.

Unknown Supplier/Provider - The carrier/*A/B MAC* enters in the appropriate column all suppliers/providers with specialty code 88.

Certified Clinical Nurse Specialist - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 89.

Medical Oncology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 90.

Surgical Oncology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 91.

Radiation Oncology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 92.

Emergency Medicine - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 93.

Interventional Radiology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 94.

Physician Assistant - The carrier/*A/B MAC* enters in the appropriate column all practitioners with specialty code 97.

Gynecological Oncology - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 98.

Unknown Physician Specialty - The carrier/*A/B MAC* enters in the appropriate column all physicians with specialty code 99.

Total Physicians and Non-Physician Practitioners - The carrier/*A/B MAC* enters in the appropriate month column (columns 1, 2 & 3) the total of all specialty codes applicable to physicians and non-physician practitioners.

470.5 – Exhibit

(Rev. 191, Issued: 07-13-11, Effective: 07-01-11, Implementation: 07-05-11)

Exhibit 1 Quarterly Opt Out Report – Carrier/*A/B MAC* – Screen 1

SCREEN 1
PHYSICIAN/NON PHYSICIAN PRACTITIONER QUARTERLY OPT OUT REPORT
CONTRACTOR NO.________________ STATE: _____________________

EXPLANATION OF SPECIALTY CODES:

01 General Practice
02 General Surgery
03 Allergy/Immunology
04 Otolaryngology
05 Anesthesiology
06 Cardiology
07 Dermatology
08 Family Practice
09 Interventional Pain Management
10 Gastroenterology
11 Internal Medicine
12 Osteopathic Manipulative Medicine
13 Neurology
14 Neurosurgery

SPECIALTY CODE/GROUP	PHYSICIAN/NON PHYSCIAN PRACTITIONER OPT OUTS				
Carrier/*A/B MAC*	Month # 1 of the Quarter	Month # 2 of the Quarter	Month # 3 of the Quarter	Quarter Total	Total on File
01-PHY					
02-PHY					
03-PHY					
04-PHY					
05-PHY					
06-PHY					
07-PHY					
08-PHY					
09-PHY					
10-PHY					
11-PHY					
12-PHY					
13-PHY					
14-PHY					

For further definition of specialty categories, see Section 470.3.

Exhibit 1 **Quarterly Opt Out Report – Carrier/*A/B MAC* – Screen 2**

SCREEN 2
PHYSICIAN/NON PHYSICIAN PRACTITIONER QUARTERLY OPT OUT REPORT
CONTRACTOR NO.________________ STATE: _____________________
EXPLANATION OF SPECIALTY CODES:

16 Obstetrics/Gynecology
17 Hospice & Palliative Care
18 Ophthalmology
19 Oral Surgery (Dentists Only)
20 Orthopedic Surgery
21 Cardiac Electrophysiology
22 Pathology
23 Sports Medicine
24 Plastic and Reconstructive Therapy
25 Physical Medicine and Rehabilitation
26 Psychiatry
27 Geriatric Psychiatry
28 Colorectal Surgery
29 Pulmonary Disease
30 Diagnostic Radiology

SPECIALTY CODE/GROUP	PHYSICIAN/NON PHYSCIAN PRACTITIONER OPT OUTS				
Carrier/*A/B MAC*	Month # 1 of the Quarter	Month # 2 of the Quarter	Month # 3 of the Quarter	Quarter Total	Total on File
16-PHY					
17-PHY					
18-PHY					
19-PHY					
20-PHY					
21-PHY					
22-PHY					
23-PHY					
24-PHY					
25-PHY					
26-PHY					
27-PHY					
28-PHY					
29-PHY					
30-PHY					

For further definition of specialty categories, see Section 470.3.

Exhibit 1 **Quarterly Opt Out Report – Carrier/*A/B MAC* – Screen 3**

SCREEN 3
PHYSICIAN/NON PHYSICIAN PRACTITIONER QUARTERLY OPT OUT REPORT
CONTRACTOR NO.________________ STATE: _____________________
EXPLANATION OF SPECIALTY CODES:

32 Anesthesiologist Assistants
33 Thoracic Surgery
34 Urology
36 Nuclear Medicine
37 Pediatric Medicine
38 Geriatric Medicine
39 Nephrology
40 Hand Surgery
41 Optometry
42 Certified Nurse Midwife
43 CRNA Anesthesia Assistant
44 Infectious Disease
46 Endocrinology
48 Podiatry

SPECIALTY CODE/GROUP	PHYSICIAN/NON PHYSCIAN PRACTITIONER OPT OUTS				
Carrier/*A/B MAC*	Month # 1 of the Quarter	Month # 2 of the Quarter	Month # 3 of the Quarter	Quarter Total	Total on File
32-NPP					
33-PHY					
34-PHY					
36-PHY					
37-PHY					
38-PHY					
39-PHY					
40-PHY					
41-PHY					
42-NPP					
43-NPP					
44-PHY					
46-PHY					
48-PHY					

For further definition of specialty categories, see Section 470.3.

Exhibit 1 **Quarterly Opt Out Report – Carrier/*A/B MAC* – Screen 4**

SCREEN 4
PHYSICIAN/NON PHYSICIAN PRACTITIONER QUARTERLY OPT OUT REPORT
CONTRACTOR NO.________________ STATE: _____________________
EXPLANATION OF SPECIALTY CODES:

50 Nurse Practitioner
62 Clinical Psychologist (Independent)
66 Rheumatology
68 Clinical Psychologist
71 Registered Dietitian
72 Pain Management
76 Peripheral Vascular Disease
77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
80 Licensed Clinical Social Worker
81 Critical Care (Intensivist)
82 Hematology

SPECIALTY CODE/GROUP	PHYSICIAN/NON PHYSCIAN PRACTITIONER OPT OUTS				
Carrier/*A/B MAC*	Month # 1 of the Quarter	Month # 2 of the Quarter	Month # 3 of the Quarter	Quarter Total	Total on File
50-NPP					
62-NPP					
66-PHY					
68-PHY					
71-NPP					
72-PHY					
76-PHY					
77-PHY					
78-NPP					
79-NPP					
80-NPP					
81-PHY					
82-PHY					

For further definition of specialty categories, see Section 470.3.

Exhibit 1 **Quarterly Opt Out Report – Carrier/*A/B MAC* – Screen 5**

SCREEN 5
PHYSICIAN/NON PHYSICIAN PRACTITIONER QUARTERLY OPT OUT REPORT
CONTRACTOR NO.________________ STATE: _____________________
EXPLANATION OF SPECIALTY CODES:

83 Hematology/Oncology
84 Preventive Medicine
85 Maxillofacial Surgery
86 Neuropsychiatry
88 Unknown Supplier/Provider
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
97 Physician Assistant
98 Gynecological Oncology
99 Unknown Physician Specialty

SPECIALTY CODE/GROUP	PHYSICIAN/NON PHYSCIAN PRACTITIONER OPT OUTS				
Carrier/*A/B MAC*	Month # 1 of the Quarter	Month # 2 of the Quarter	Month # 3 of the Quarter	Quarter Total	Total on File
83-PHY					
84-PHY					
85-PHY					
86-PHY					
88-NPP					
89-NPP					
90-PHY					
91-PHY					
92-PHY					
93-PHY					
94-PHY					
97-NPP					
98-PHY					
99-PHY					
Total					

For further definition of specialty categories, see Section 470.3.

480 - Special Purpose Data

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

480.1 - Heading

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

This report, referenced as Form Y in the CROWD system, is used only when program requirements compel CMS to collect data on an interim basis before the data elements can be incorporated into one of the regular forms. The Medicare contractor will submit the form via the CROWD system no later than the 10th day of the following month.

480.2 - Exhibit

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Exhibit - Special Purpose Data

SPECIAL PURPOSE DATA

CONTRACTOR	NUMBER					
DESCRIPTION	CODE	COL 1	COL 2	COL 3	COL 4	COL 5
	0000	0	0	0	0	0
	0000	0	0	0	0	0
	0000	0	0	0	0	0

490 – Form 9 for Primary Care Incentive Program (PCIP) Payments and HPSA Surgical Incentive Program (HSIP) Payments

(Rev. 195, Issued: 09-30-11, Effective: 07-01-11, Implementation: 07-05-11)

Section 5501(a) of the ACA revised Section 1833 of the Social Security Act (the Act) by adding new paragraph (x), "Incentive Payments for Primary Care Services." Section 5501(b) of the ACA revised Section 1833 of the Act by adding new paragraph (y) "Incentive Payments for Major Surgical Procedures Furnished in Health Professional Shortage Areas." In both cases, the statutes authorize incentive payment programs under Medicare.

CROWD report Form 9 is established to report the PCIP and HSIP Medicare incentive payment program data. Contractor reporting will begin after the close of the 3rd quarter of 2011. Form 9 submissions shall be completed for each workload number and will be due by the 15th day after the close of each quarter.

Note: The first submission due October 17, 2011 shall include incentive payment data for the preceding incentive quarters of 2011.

***NOTE:** CROWD Form 9 will require FISS reporting to accumulate PCIP and HSIP payments made to CAHs.*

Please refer to Pub. 100-04, Chapter 12, Section 230 for eligibility and implementation of the PCIP and Pub. 100-04, Chapter 12, Section 90.4.11.1 for eligibility and implementation of the HSIP.

490.1 – Category 1: Practitioners Receiving Incentive Payments
(Rev. 195, Issued: 09-30-11, Effective: 07-01-11, Implementation: 07-05-11)

Medicare contractors shall prepare and submit to CMS a quarterly report regarding the number of physicians, nonphysician practitioners, and CAHs who have received PCIP and HSIP payments in the prior quarter. Each contractor shall complete CROWD Form 9 for every state in its jurisdiction. Contractors shall code their systems to enter the total number of practitioners receiving PCIP payments in reporting code 2 and the total number of CAHs receiving PCIP payments in reporting code 3. Contractors shall code their systems to enter the total number of practitioners receiving HSIP payments in reporting code 4 and the total number of CAHs receiving HSIP payments in reporting code 5. Contractors do not submit a hard copy, faxed copy or e-mail version of this report to CMS.

490.2 – Category 2: Summation of Incentive Payments
(Rev. 195, Issued: 09-30-11, Effective: 07-01-11, Implementation: 07-05-11)

Medicare contractors shall prepare and submit to CMS a quarterly report regarding the sum of incentive payments made to physicians, nonphysician practitioners, and CAHs who have received PCIP and HSIP payments in the prior quarter. Each contractor shall complete CROWD Form 9 for every state in its jurisdiction. Contractors shall code their systems to enter the sum of payments made to practitioners receiving PCIP payments in reporting code 7 and the sum of payments made to CAHs receiving PCIP payments in reporting code 8. Contractors shall code their systems to enter the sum of payments made to practitioners receiving HSIP payments in reporting code 9 and the sum of payments made to CAHs receiving HSIP payments in reporting code 10. Contractors do not submit a hard copy, faxed copy or e-mail version of this report to CMS.

490.3 – Exhibits
(Rev. 195, Issued: 09-30-11, Effective: 07-01-11, Implementation: 07-05-11)

File Layout: Contractor Reporting of Operational and Workload Data (CROWD) Form 9

Category 1: Practitioners Receiving Incentive Payments
1 = Total (numeric)
2 = PCIP Practitioners
3 = PCIP CAH
4 = HSIP Practitioners
5 = HSIP CAH
Category 2: Summation of Incentive Payments
6 = Total (monetary)
7 = PCIP Practitioners

8 = PCIP CAH
9 = HSIP Practitioners
10 = HSIP CAH

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R195FM	09/30/2011	To Create Form 9 Within the Contractor Reporting of Operational and Workload Data (CROWD) System for the Reporting of Primary Care Incentive Payments (PCIP) and HPSA Surgical Incentive Payments (HSIP)	07/05/2011	7285
R191FM	07/13/2011	Add Physician Specialty Codes for Cardiac Electrophysiology (21) and Sports Medicine (23) to CROWD Forms "F" (ParDoc) and "8" (OptOut) – Rescinded and replaced by Transmittal 191	07/05/2011	7233
R188FM	04/22/2011	Modify CROWD Form K to Allow the Submission of Additional Medicare Summary Payer (MSP) Savings Information	07/05/2011 and 10/03/2011	7291
R183FM	02/04/2011	To Create Form 9 Within the Contractor Reporting of Operational and Workload Data (CROWD) System for the Reporting of Primary Care Incentive Payments (PCIP) and HPSA Surgical Incentive Payments (HSIP) – Rescinded and replaced by Transmittal 195	07/05/2011	7285
R181FM	01/04/2011	Add Physician Specialty Codes for Cardiac Electrophysiology (21) and Sports Medicine (23) to CROWD Forms "F" (ParDoc) and "8" (OptOut) – Rescinded and replaced by Transmittal 191	07/05/2011	7233
R178FM	12/03/2010	Add Physician Specialty Codes for Cardiac Electrophysiology (21) and Sports Medicine (23) to CROWD Forms "F" (ParDoc) and "8" (OptOut) - Rescinded and replaced by Transmittal 181	07/05/2011	7233
R177FM	12/03/2010	Add Supplier Specialty Code 95 (Advanced Diagnostic Imaging (ADI) Accreditation) to CROWD Form F (Participating Physician/Supplier Report) – Rescinded and not replaced.	07/05/2011	7226
R176FM	11/12/2010	Clarification for Data Entry on Health Professional Shortage Area Reports	12/13/2010	7223
R175FM	10/28/2010	Change the Name of Physician Specialty Code 12 from Osteopathic Manipulative Therapy to Osteopathic Manipulative Medicine	04/04/2011	7093
R173FM	10/15/2010	Update to the Quarterly Opt Out Reporting Form (Form 8) in the Contractor Reporting of Operational Workload Data (CROWD)	11/16/2010	7165
R171FM	05/28/2010	Expansion of Form 5 of the Contractor Reporting of Operational and Workload Data (CROWD)	10/04/2010	6969
R170FM	05/21/2010	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation	10/04/2010	6850

R163FM	12/04/2009	Add Physician Specialty Code 27 (Geriatric Psychiatry) to CROWD Form F (Participating Physicians/Supplier Report)	04/05/2010	6613
R159FM	10/09/2009	Add Physician Specialty Code 27 (Geriatric Psychiatry) to CROWD Form F (Participating Physicians/Supplier Report) – Rescinded and replaced by Transmittal 163	04/05/2010	6613
R157FM	08/21/2009	Add Specialty Codes to CROWD Form F (Participating Physicians Data)	01/04/2010	6580
R155FM	07/31/2009	New Reporting Requirements for the Quarterly Opt Out Report in Contractor Reporting of Operational Workload Data (CROWD)	01/04/2010	6562
R144FM	11/28/2008	Revisions to the Monthly Statistical Report on Intermediary and Carrier Part A and Part B Appeals Activity Form (CMS-2592) to Capture Data on Recovery Audit Contractor (RAC) Redeterminations	04/06/2009	6251
R131FM	09/21/2007	Participating Physicians Report – Deletion of Requirement to Forward a Memorandum to CMS Detailing Adjustments for Form F Column 1 (PAR Prior) (from previous enrollment period)	01/07/2008	5697
R130FM	08/31/2007	“Revisions” of the CROWD Report	01/07/2008	5555
R126FM	07/13/2007	Manual Revision Re: MSN Workload Reporting	01/07/2008	5642
R123FM	06/08/2007	Contractor CROWD Form 5 Completion Changes	10/01/2007	4274
R121FM	05/02/2007	Contractor CROWD Form 5 Completion Changes – Replaced by Transmittal 123	10/01/2007	4274
R119FM	04/20/2007	Contractor CROWD Form 5 Completion Changes - Replaced by Transmittal 121	10/01/2007	4274
R98FM	06/16/2006	Correction of CROWD Form 5 Reporting for Internet Pilot Carriers	07/17/2006	5120
R96FM	05/26/2006	Development of New Report to Capture BIPA and MMA Appeals Data	07/03/2006	5056
R88FM	01/06/2006	Clarification to IOM 100-06, Sections 290.7 and 290.8	02/06/2006	4198
R86FM	12/02/2005	Development of New Report to Capture BIPA and MMA Appeals Data – Replaced by Transmittal 96, CR 5056	07/03/2006	4148
R85FM	11/17/2005	Expansion of Form 5 of the Contractor Reporting of Operational and Workload Data (CROWD) – Replaced by Transmittal 85	04/03/2006	3864
R82FM	10/31/2005	Expansion of Form 5 of the Contractor Reporting of Operational and Workload Data (CROWD) – Replaced by Transmittal 85	04/03/2006	3864
R76FM	08/12/2005	Development of New Report to Capture BIPA and MMA Appeals Data – Replaced by Transmittal 86, CR 4148	04/03/2006	3837

R65FM	02/25/2005	Revised Reporting Requirements for Contractor Reporting of Operational and Workload Data (CROWD) Physician Scarcity Area (PSA) Quarterly Report (CMS Form-1565F, CROWD Form 6)	07/05/2005	3673
R57FM	10/22/2004	Revised Reporting Requirements for Contractor Reporting of Operational and Workload Data (CROWD) Health Professional Shortage Area (HPSA) Quarterly Report (CMS Form-1565E, CROWD Form S)	04/04/2005	3472
R56FM	10/22/2004	Revision to Balancing Requirements on Form 5, Line 10 of the Contractor Reporting of Operational and Workload Data (CROWD)	11/22/2004	3486
R45FM	05/28/2004	Workload Reporting	N/A	3246
R40FM	04/30/2004	Medicare Contractor Transaction Report	10/04/2004	3257
R36FM	03/12/2004	Medicare Contractor Transaction Report (FormCMS-5)	N/A	2249 & 2547
R06FM	08/30/2002	Initial Publication of Chapter	N/A	N/A

Back to top of Chapter